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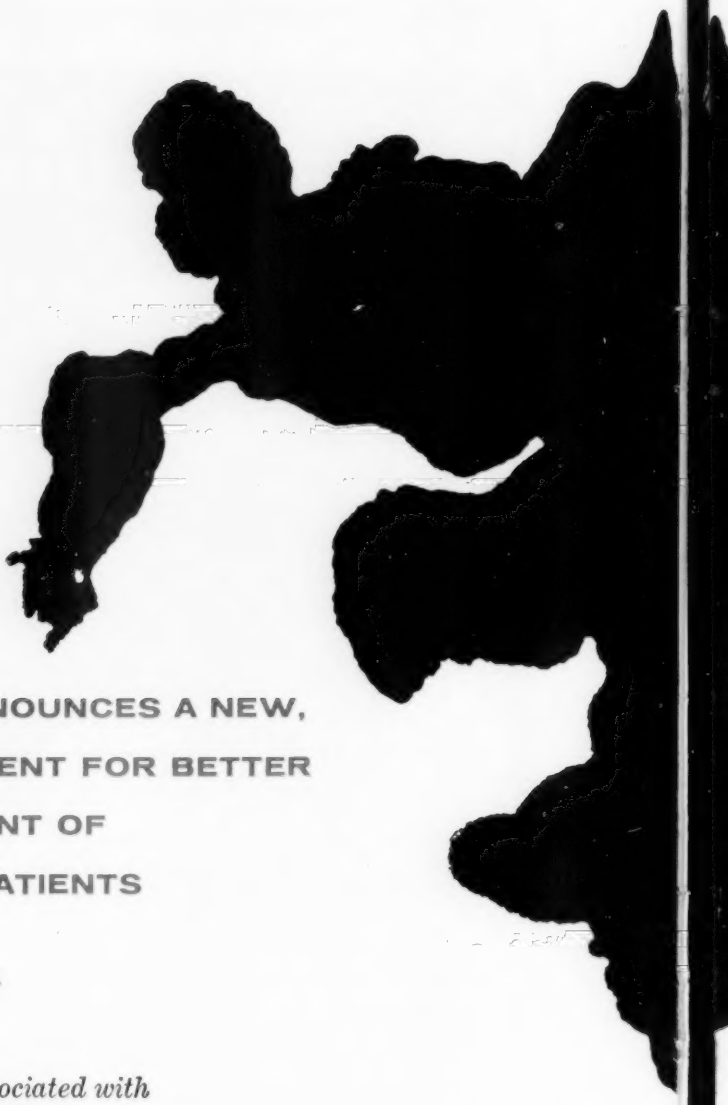

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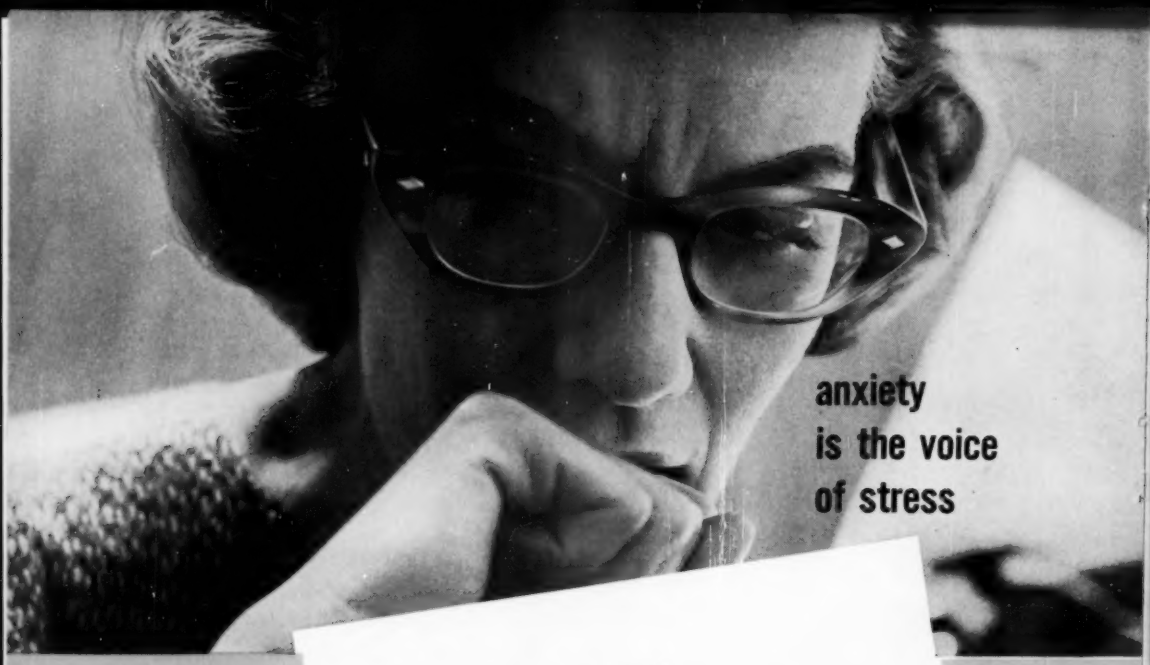

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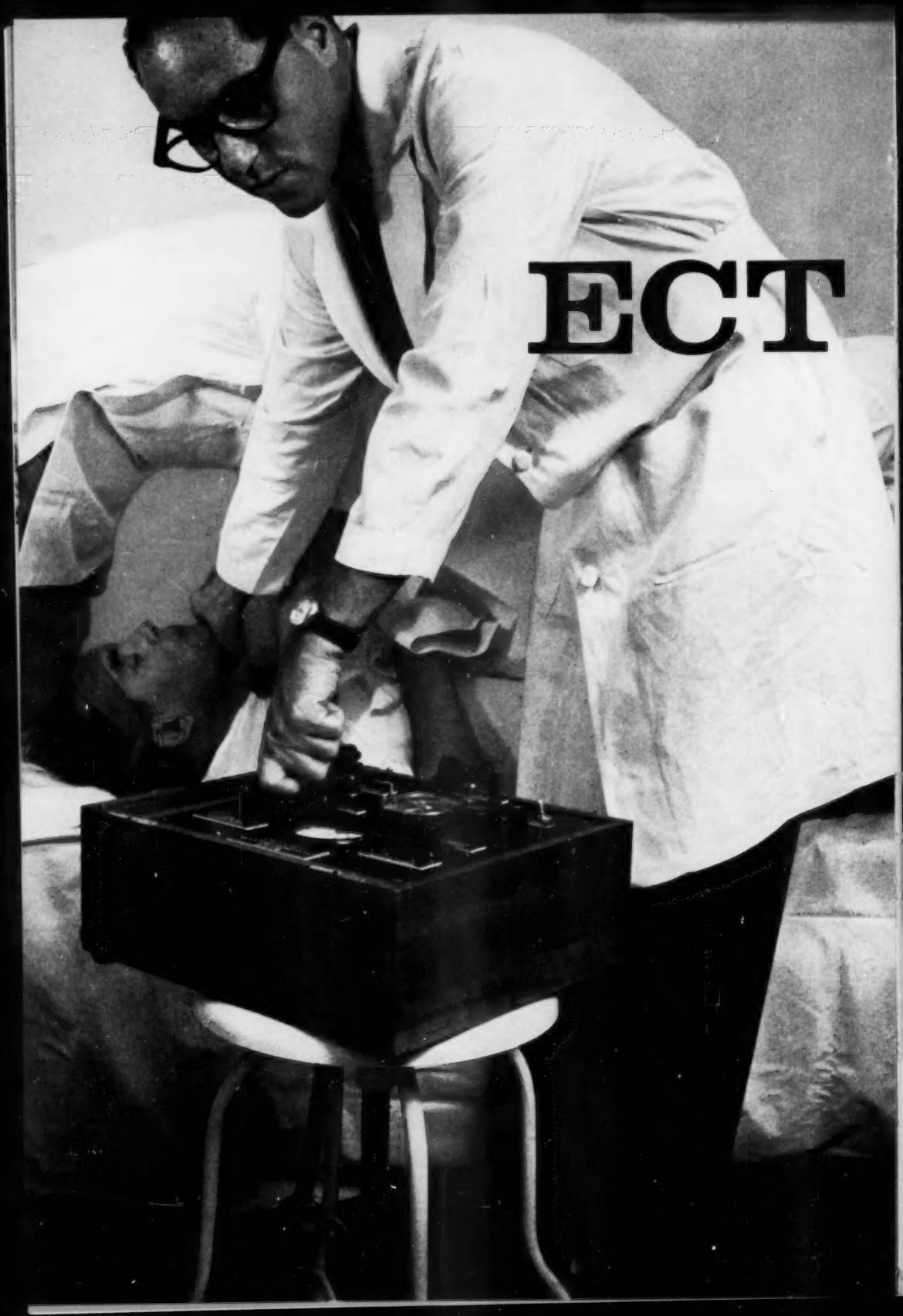
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EUGEN BLEULER'S CONCEPT OF THE GROUP OF SCHIZOPHRENIAS AT MID-CENTURY [1]

FRITZ A. FREYHAN, M.D.[2]

It seems not only important but provocative to reexamine in 1957 what Eugen Bleuler established in 1912 as his concept of the group of schizophrenias. Although this major contribution to our knowledge on schizophrenia was published in 1912, an interval of 38 years passed before an English translation found its way into the hands of American psychiatrists. The common belief prevails, nevertheless, that his ideas were accepted decades ago; that his differentiation of primary and secondary symptoms paved the way toward a psychodynamic understanding of the schizophrenic patient and thereby contributed to the development of psychotherapeutic techniques which were yet to be discovered. This is not wholly true, I believe. There is evidence which suggests that the main psychopathological conception found approval and recognition while equally important views on clinical and theoretical aspects remained either unknown or were never assimilated. In my attempt to evaluate Bleuler's ideas in the light of contemporary concepts, I shall feel encouraged by his conviction: "Errors are the greatest obstacle to the progress of science; to correct such errors is of more practical value than to achieve new knowledge." The range and the content of psychiatry have been greatly extended in the first half of this century. It is well to remember, nevertheless, that unawareness of some cornerstones of Bleuler's concept of schizophrenia accounts for errors and detours on the road to scientific and therapeutic achievement.

If one turns to the developments of the recent past and present, one can easily sympathize with an impression of Manfred Bleuler who reviewed the changes in concepts in the study of schizophrenia in the years 1940-1950:

> Thirty years ago, in spite of frontiers and oceans, there was still a common understanding on the basis of certain fundamental concepts which were shared by everyone. Today, the trend of scientific thought, the spheres of scientific interest and scientific nomenclature have grown so far apart and become so independent within the various schools of thought and countries that even acknowledged authorities on the subject are at times no longer able to communicate with each other.

We may wish to determine what are fundamentally divergent views which must exist side by side awaiting scientific confirmation or disproof and what, on the other hand, are variations of old themes or rediscoveries of facts well known to preceding generations. There is no sense in denying the naturalness of a generation-centered point of view. But scientific progress presupposes the ascertainment and recording of facts to ensure an organic, cumulative growth of knowledge. We need in psychiatry the cultivation of the historian's point of view which, in Toynbee's words, requires that "the historian arrives at his professional point of view by consciously and deliberately trying to shift his angle of vision away from the initial self-centered standpoint that is natural to him as a living creature." Peculiarly enough, the psychiatrist as scientist tends to live solely in the present but effectively turns historian when assuming the role of psychotherapist. There should be no reason why his sharpened perceptiveness of genesis could not contribute to his dynamic understanding of the scientific present as the continuation of the past.

The historian's sense of continuity is a prerequisite for a comprehensive understanding of Bleuler's concept of the schizophrenias. There is little about schizophrenic patients, about the nature of their being sick, their fate in life and about the therapeutic modifiability of their symptoms which escaped the observing and exploring mind of the man who not only worked but lived in psychiatric hospitals, devoting many years to very close associations with schizophrenic patients. What makes his book, *Dementia Praecox or the Group of Schizophrenias,* as Zilboorg reminds us "the classical work of twentieth century psychiatry," is not only

[1] Read at the 113th annual meeting of The American Psychiatric Association, Chicago, Ill., May 13-17, 1957.

[2] Assistant Professor of Psychiatry, University of Pennsylvania, Philadelphia, Pa.

the original conception of psychopathology, but the unparalleled scope of treatment which ranges from physiological to psychological theory, from social management to critical exploration of clinical therapies, from evaluation of epidemiological aspects to penetrating analyses of schizophrenic personalities.

If we now cast a glance back over the past 38 years, we can hardly escape the impression that a great deal of effort was spent on rediscovering what Bleuler had elaborated with compelling clarity. To begin with the all important definition of schizophrenia, he had stated:

> By the term 'dementia praecox' or 'schizophrenia' we designate a *group of psychoses* [italics mine] whose course is at times chronic, at times marked by intermittent attacks, and which can stop or retrograde at any stage, but does not permit a full *restitutio ad integrum*. The disease is characterized by a specific type of alteration of thinking, feeling, and relation to the external world which appears nowhere else in this particular fashion.

Here is evident beyond controversy that Bleuler divorced not only the diagnosis from outcome, but stressed the variability of course and severity. His emphasis on range, variability and, most crucial, reversibility of schizophrenic manifestations, forms the cornerstone of his concept. To go no further than this, the perplexing fact remains that the notion of schizophrenia as a hopeless disease did not die. Notwithstanding statistical evidence of modes of recoverability, however defined—and it should not be forgotten that Kraepelin reported 17% social recoveries by the most modest of standards—newer approaches were time and again acclaimed because they bore the marks of optimism. At the 1950 conference at Yale on schizophrenia and psychotherapy, research from one of this country's foremost clinics was reported with this introduction:

> This research began and developed in an atmosphere pervaded by a consistent spirit of optimism regarding the treatability of schizophrenia—a premise which has prevailed in this institution since its inception, even when it was the general opinion that a recovery in supposed schizophrenia disproved that diagnosis.

The author then acknowledges the support afforded him by the "scientific conviction" of his colleagues "that schizophrenia is by no means a hopeless disease." It would certainly be unfair to single out this report as if its peculiar assertions were unique. But it conveys a common obsession: to propound a new therapeutic approach with a message of optimism. How can we serve the cause of scientific progress, we must honestly ask ourselves, if we feel compelled to advocate as new what amounts to mere repudiation of an anachronistic cliché?

We cannot ignore that Bleuler found it impossible to recognize any uniformity in the course of the disease:

> One comes closest to reality if one makes it clear that merely the general direction of the course of this disease is toward a schizophrenic deterioration, but that in each individual case the disease may take a course which is both qualitatively and temporally rather irregular. Constant advances, halts, recrudescences, or remissions are possible at any time.

He left no doubt that "true arrests in the progress of the disease may appear at any time." His observations of the importance of external influences—which Kraepelin later confirmed—are highly modern in their practical significance:

> Definitive or transitory improvements occur spontaneously, or in connection with psychic influences or factors such as transfer to another place, a release, a visitor. . . . These improvements occur significantly less frequently in the chronic conditions than in the acute, but are not completely absent from the former.

Accordingly, he insists that it is essential that external circumstances be changed:

> If the patients are permitted to remain always in the same set of surroundings, they easily become more and more encased in their disease and proportionally less accessible.

Bleuler's lucid and highly practical ideas on evaluation anticipated some of the errors which were to cloud the validity of statistics concerned with modern therapies. Since he did not believe in a full *restitutio ad integrum*, he stated: "We do not speak of cure but of far-reaching improvements." Disputing the more optimistic reports of other authors who claimed cures, he expressed his doubt with the observation that he had never released a schizophrenic "in whom I could not still see distinct signs of the disease; indeed, there are very few in whom one would have to search for such

signs." Yet he added: "I know schizophrenics who, after their illness, have conducted and developed complicated business." To understand what Bleuler envisaged as far-reaching improvements, we must turn to his choice of criteria. These sound ominous if taken verbally since they are based on the "severity of the deterioration." But he explains "those capable of earning a living, I call cases of 'mild deterioration'; those completely incapable of social living are called 'severe deterioration'; the intermediary types who do not fit into either of these two categories are placed as medium deterioration." Obviously, what he modestly called "mild deterioration" corresponds to the social recoveries as used by others. His comments on the pitfalls of statistics will capture the respect, if not admiration, of our biometricians. Warning that "varying conditions of admission and release determine the average prognosis of the disease in that institution," he minimizes the value of reported results: "Any figures, then, will serve to estimate not schizophrenia as such, but the schizophrenics admitted to any given hospital."

I have always wondered why the following figures, referring to his group of 515 cases, admitted to the Burghoelzli hospital between 1898-1905, have found little, if any, comment: mild deteriorations, *i.e.*, capable of earning a living, 60%; medium deterioration 18%, and severe deterioration 22%. Bleuler cautioned: "Naturally, these results get considerably worse with time. Yet, few of those with a good remission have had to be returned to the hospital for permanent commitment because of a later exacerbation of the disease." Results such as these are remarkable even by modern standards. It does not matter whether his cases were milder, his criteria for improvement more liberal or the tolerance of Swiss communities toward patients more pronounced than elsewhere. Nor do we need to be concerned with factors of a statistical nature. However, we cannot escape the question whether his conviction, that it be "preferable to treat these patients under their usual conditions and within their habitual surroundings" did not stem from a profound realization of adaptive potentialities as well as therapeutic limitations. By expecting less, he apparently achieved more. Instead of nursing ideal concepts on cure, he concentrated on implementing practices of social adaptation. This naturalistic attitude met the resistance of those who adhered to a more puristic concept of cure. At the symposium "Schizophrenia: an investigation of the most recent advances," held under the auspices of the Association for Research in Nervous and Mental Diseases in 1929, the ever-present controversy between naturalists and purists had gained momentum. Sullivan, rejecting recovery as "remission" or "arrest," stated categorically:

> An individual who has undergone a schizophrenic illness, ceased to show schizophrenic processes and resumed social living with a gradual expansion of life-interests, has in fact to the limit of the meaning of such terms actually recovered from the schizophrenic illness.

Zilboorg, on the other hand, distinguished between "social recovery" and "medical recovery" and doubted that "social recovery alone is a guarantee against the recurrence or against a gradual continuation and further development of the schizophrenic process," since the socially recovered patients "with very rare exceptions, fail to establish a complete affective contact with reality." Advocating the need of thorough psychological reconstruction, Zilboorg represented the puristic point of view, leaving judgement as to the superiority of his therapeutic method to the future. Unfortunately, few, if any, of the then anticipated follow-up studies of the results of analytical therapy have ever been carried out or presented. Hinsie, to whom had fallen the task of criticism of treatment and recovery as reported at the conference, observed that

> the results reported by the psychotherapeutists can be duplicated by the somato-therapeutists. . . . What the psychiatrist needs before he can place a fair appraisal upon his treatment measures, is a clearer conception of the ordinary nosological factors in this type of disorder. He needs to have an accurate knowledge of the entire course of schizophrenia.

What was said in 1929, is still being argued today. The naturalists compare therapeutic results with spontaneous recoveries, while the purists insist on the therapeutically achieved elimination of fundamental pathology, whether through somatic methods

or psychological reconstruction of the personality.

The question of spontaneous courses has not been resolved. There are those who deny the usefulness of considerations of a natural course of mental disorders. Stanton sees "little more reason for thinking of a natural history of the disease than of a natural history of church membership." But few would deny that the concept of spontaneous courses, far from presupposing etiological determinants of duration, differentiates modes of outcome on the basis of prevailing developments which can be ascertained by catamnestic methods. Bleuler's reluctance to refer to "results" when describing "outcome," stems from the sober recognition that the former connotes a consequential relation, whereas the latter does not. With characteristic candor, he introduced the chapter on therapy with this guiding thought: "Except for the treatment of purely psychogenic disorders, the therapy of schizophrenia is one of the most rewarding for the physician who does not ascribe the results of the natural healing processes of psychosis to his own intervention." Whether to credit this statement with the wisdom of therapeutic insight or blame it for the implication of therapeutic limitations, depends essentially on one's "initial self-centered standpoint." I am tempted to believe that what Bleuler meant, differs but little from F. Alexander's comments on the healing of psychotherapy:

> In our young field, we have not yet emancipated ourselves from the magical traditions of medicine. Modern medicine recognizes that healing is possible only because of the regenerative powers of the organism. It recognizes that a physician's function is to create conditions in which the regenerative powers can best act by removing obstacles.—Primarily nature and not the physician heals; the physician only helps the healing process.—The surgeon can only favor this healing process but cannot initiate it. The same is true for psychotherapy and psychoanalysis.

In a conceptual sense, the therapist of 1912 and 1955 hold in common the conviction that nature heals while the physician creates the conditions which enhance the regenerative powers. This is the major reason for Bleuler's demand that:

> one should not wait for a 'cure'. One can consider it an established rule that earlier release produces better results.—In particular, we must consider the qualities of the patient's relatives; they may as easily ruin the patient as they may continue his education.—The only, and often very practical, criterion is the patient's capacity to react in a positive manner to changes in environment and treatment.

The multitude of clinical and prognostic aspects of schizophrenia suggested to Bleuler groups rather than an entity. But there is no doubt that his concept is identical with Kraepelin's in as far as the actual disease concept is concerned:

> We are dealing with a group of diseases which is differentiated on principle from all other Kraepelinian groups. One of the most common objections which is still being voiced, especially in foreign countries, is, strangely enough, that we are not always dealing with either dementia praecox or precocious dementia. Considering Kraepelin's clear definition of the concept and his emphatic mention of cures and of the incidence in older age groups, an objection such as this must be termed a gross misunderstanding on the part of those who do not want to recognize the concept and who instead continue to cling to names.

But while this disease concept includes symptoms which occur only and always in schizophrenia, Bleuler conceded the possibility of different etiological factors leading to the same symptomatic picture. He, therefore, regarded schizophrenia "not as a species of disease but as a genus" not unlike the group of organic psychoses.

As to the nature of "the disease process," he admitted: "We do not know what the schizophrenic process actually is." Convinced that only a somatic process could account for the disease, he did not exclude psychological etiology: "It is conceivable that the entire symptomatology may be psychically determined and that it may develop on the basis of slight quantitative deviations from the normal. . . ." Nevertheless, he gave serious attention to the toxin-theory for which he found some support in the work of Berger. In his experimental studies, Berger had found evidence of a toxin in the blood of catatonic patients which had exciting effects on the cortical motor center of dogs. Berger reported this in 1904. The assumption of a toxicogenic etiology was shared by Kraepelin who, advising great caution with regard to forming opinions on the subject, thought of "an auto-intoxication in consequence of a disorder of metabolism." Such hypotheses do not sound as far-fetched

today as they may have in the recent past. The current work of Heath, Hoffer and others, suggesting that oxidized derivatives of epinephrine constitute etiological factors in the genesis of schizophrenia, has not only revived interest in the toxin-theory; it illustrates once more that the cycle of themes and variations of concepts continues.

In summing up what Bleuler offered in support of his concept of the group of schizophrenias, we have first and foremost his observation of very dissimilar courses in the fact of highly similar symptomatologies. The discrepancies between life-long deterioration in some, and temporary illness followed by life-long readaptation in other schizophrenics, rendered the assumption of a uniform disease more than doubtful. Yet, common clinical manifestations as well as evidence of consistent differences in prognostic patterns suggested the existence of particular groups with generic boundaries.

FURTHER OBSERVATIONS OF THE COURSES OF SCHIZOPHRENIA

Bleuler's concept stands or falls with the confirmation of varieties of spontaneous courses characterized by consistent similarities. To examine the actuality of this concept requires that this be done within the dimension of time. What are the facts which transcend the immediacy of clinical experience; what the changes from past to present? Keeping in mind Bleuler's dictum that "any figures will serve to estimate not schizophrenia as such, but the schizophrenics admitted to any given hospital," I offer an analysis of developments which concern the hospitalized schizophrenic patients in Delaware in the years 1900-1950. Such a study of all schizophrenics, first admitted during a 51-year period, has substantial advantages if we consider the special situation in Delaware, a small state with the Delaware State Hospital as the only psychiatric hospital for every need of the state's total population. The usual difficulties, arising from selective factors in the composition of hospital populations, are reduced to the very minimum. As the only psychiatric hospital in the state, it admits patients from urban and rural areas, representing all socio-economic classes. There are units for private, semi-private and ward patients. In the absence of other psychiatric inpatient services in the state, patients are admitted as early—or late—as first recognized to be in need of hospital treatment. Close contacts between patient, family and hospital are established and maintained through the years. Perhaps most important is the fact that every additional hospitalization during the life of patients means readmission to the Delaware State Hospital. These circumstances provide a high degree of observational control and first-hand knowledge. In more than one sense, then, this material does not only tell the story of the schizophrenics in one hospital, but of the hospitalized schizophrenics in one state.

The total number of 1,488 patients includes the 1920 and 1940 groups about which I reported in a previous study. The patients are divided into 7 cohorts. All but the last include admissions during 8-year periods. The 1948-1950 cohort is restricted to 3 years to permit a minimum of 5 years follow-up. It should be emphasized that all data pertain to each patient's status on 1-1-56. We are interested in the following questions:

a. How many patients were admitted only once; to improve, leave and never to return; or to remain continuously hospitalized. These patients are reported as *single admissions.* (S).

b. How many patients improved sufficiently to leave the hospital but returned for one or several additional admissions. Out of this group of separated patients, how many reached eventually a stable state of improvement and separation; or grew worse to require continuous hospitalization. These patients are reported as *multiple admissions* (M).

c. How many patients died in the hospital of indirect consequences of the psychoses.

ANALYSIS

Figure 1 surveys the over-all developments for each cohort. Most apparent is the growing rate of separations, ranging from 38.8% in the cohort of 1900-1907 to 84% in the cohort of 1948-1950. The chances for leaving the hospital following the first admission, thus, rose from 4 in 10 to 4 in 5. We notice the growing number of admis-

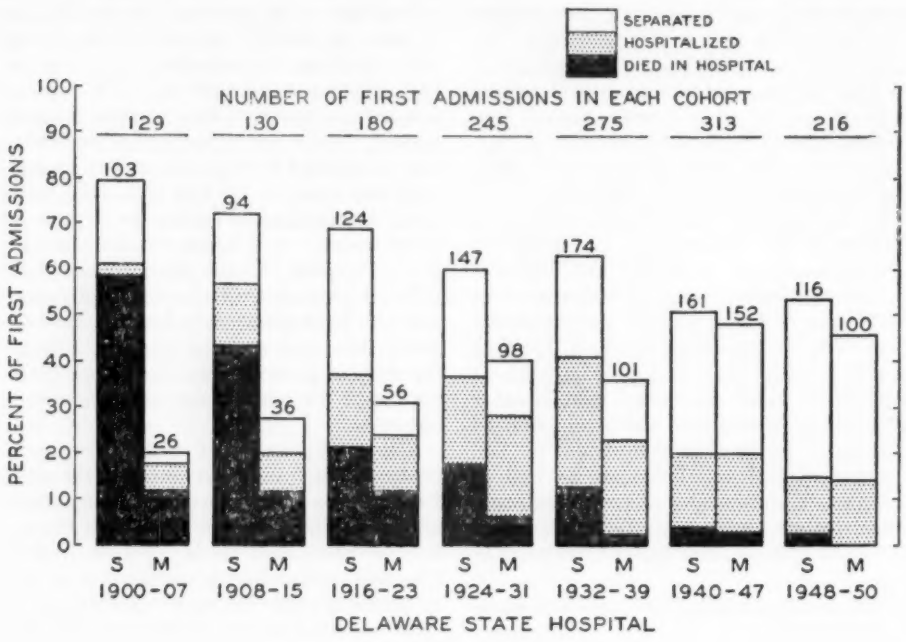

FIG. 1

sions from cohort to cohort. As separations increased, so did multiple admissions.

Figures 2 and 3 reveal the developments on the 5 and 10-year level. This makes it possible to compare the cohorts on equal temporal terms.

Figure 4 illustrates the developments within the first 10 years in greater temporal detail. To focus attention on the major differences, the first and the last 2 cohorts have been singled out. (The intermediary cohorts fill the space between the 1907 and 1947 curves in symmetrical fashion.)

What appears well documented is the fact that separations occur early, primarily within the first 2 years. This trend has persisted through the years. But we recognize 2 major differences: 1. in the earliest period only 23%, in the most recent period 59%, had left the hospital within 6 months of admission; 2. by the end of two years, the rate of separations had increased by only 11% for the earliest, by 22% for the most recent period.

The mortality figures reveal highly significant differences within the 10-year period following admission. Mortality rates were 36% for the first, less than 4% for the last cohort (each intermediary cohort showing a further drop of mortality). The question of age differentials can hardly be omitted in this connection. The "mean age at admission for each cohort" and the "mean age at death for patients from each cohort" has been tabulated as follows:

	Mean Age	
Cohort	Admission	Death
1900-1907	38.0	54.8
1908-1915	35.6	53.3
1916-1923	29.6	51.3
1924-1931	32.6	51.8
1932-1939	31.4	50.3
1940-1947	31.1	40.4
1948-1950	31.4	45.6

The danger to life associated with complications of somatic therapies seems insignificant compared with the high death rate of earlier years.

Figure 5 represents in detail the further developments of patients who have in com-

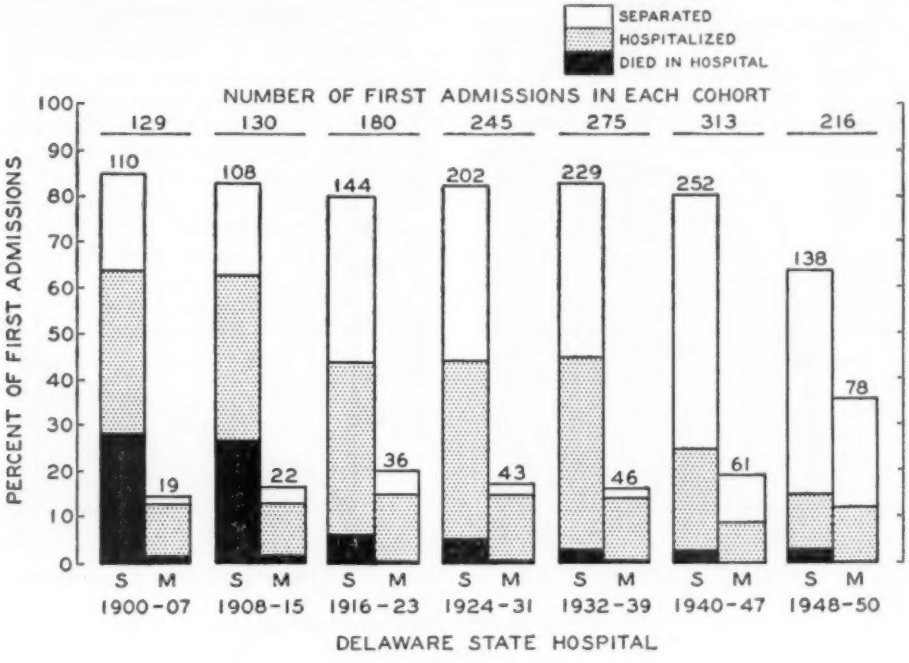
SEPARATED
HOSPITALIZED
DIED IN HOSPITAL
NUMBER OF FIRST ADMISSIONS IN EACH COHORT
129
130
180
245
275
313
216
PERCENT OF FIRST ADMISSIONS
100
90
80
70
60
50
40
30
20
10
0
110
19
108
22
144
36
202
43
229
46
252
61
138
78
S M
1900-07
1908-15
1916-23
1924-31
1932-39
1940-47
1948-50
DELAWARE STATE HOSPITAL

FIG. 2

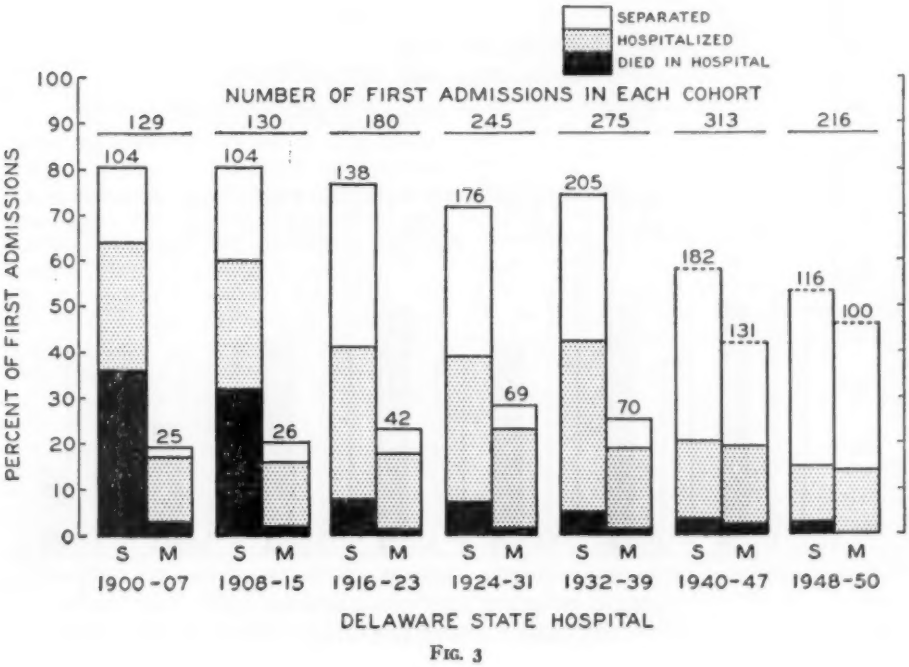
SEPARATED
HOSPITALIZED
DIED IN HOSPITAL
NUMBER OF FIRST ADMISSIONS IN EACH COHORT
129
130
180
245
275
313
216
PERCENT OF FIRST ADMISSIONS
100
90
80
70
60
50
40
30
20
10
0
104
25
104
26
138
42
176
69
205
70
182
131
116
100
S M
1900-07
1908-15
1916-23
1924-31
1932-39
1940-47
1948-50
DELAWARE STATE HOSPITAL

FIG. 3

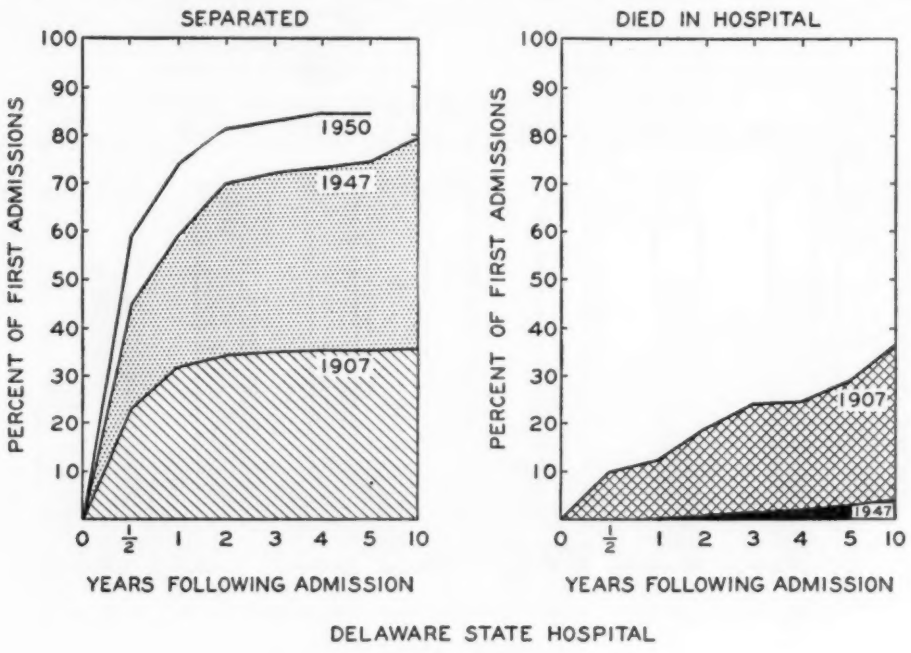
SEPARATED
DIED IN HOSPITAL
PERCENT OF FIRST ADMISSIONS
100
90
80
70
60
50
40
30
20
10
1950
1947
1907
0
½
1
2
3
4
5
10
YEARS FOLLOWING ADMISSION
DELAWARE STATE HOSPITAL

FIG. 4

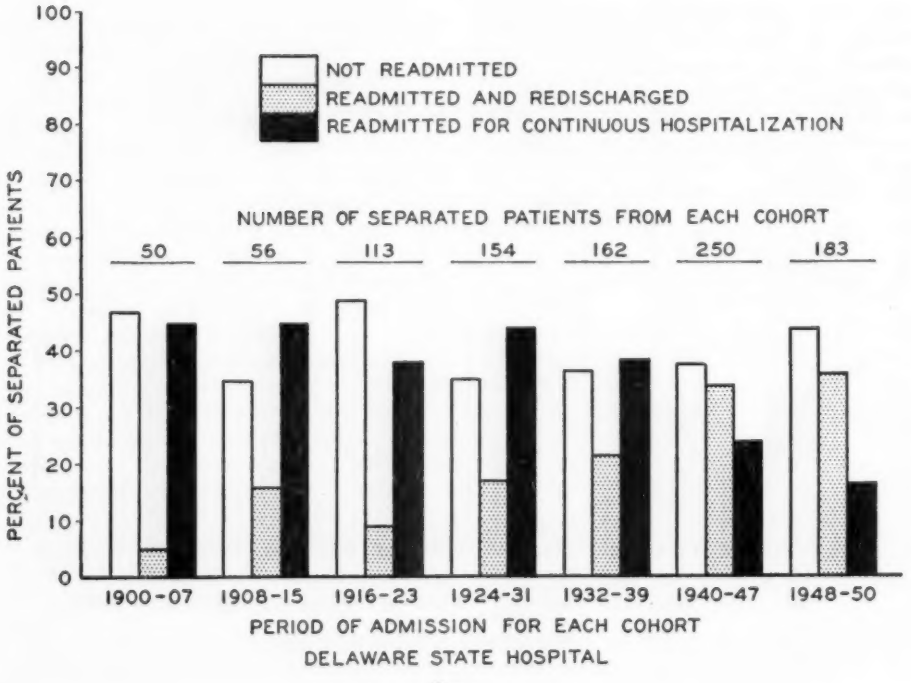
NOT READMITTED
READMITTED AND REDISCHARGED
READMITTED FOR CONTINUOUS HOSPITALIZATION
NUMBER OF SEPARATED PATIENTS FROM EACH COHORT
50
56
113
154
162
250
183
PERCENT OF SEPARATED PATIENTS
100
90
80
70
60
50
40
30
20
10
0
1900-07
1908-15
1916-23
1924-31
1932-39
1940-47
1948-50
PERIOD OF ADMISSION FOR EACH COHORT
DELAWARE STATE HOSPITAL

FIG. 5

mon separation following first admission. What seems quite significant is the rather consistent proportion of about 35-45% of patients who remained permanently separated. This constitutes the group with the most favorable prognosis. Each cohort shows that approximately one third of the patients who left the hospital, remained sufficiently stable to stay out. Marked changes are reflected in the movements of patients with multiple admissions. Formerly, their chances for eventual recovery were extremely low as indicated by the high rate of patients who remained for continuous hospitalization. A decisive change for the better occurred after 1940, when the rate of recoveries, in spite of multiple admissions, began to rise steadily.

COMMENT

Even a glance at these developments must convince us of their actual and potential significance. It is not the purpose of this analysis to enter into many deserving statistical considerations or to compare the data with those of similar studies. This will be done in another publication.

We are here concerned with the differentiation of groups on the basis of similarities of course of illness. Without any difficulty, we can make the following observations. First, there is no question of decisive changes after 1940. The introduction of somatic therapies facilitated a steady increase of separations; this is equally true for single and multiple admissions. Of no lesser importance, however, is the fact that the proportion of optimal improvements, *i.e.*, permanent separations after a single admission, remains virtually unchanged throughout the years. We find no indication that modern approaches, somatic treatments or psychotherapies, have contributed in any measurable degree toward an increase in the proportion of this group.

It would be erroneous to assume that the high rate of continuous hospitalizations during the earlier period can be blamed on the severity of the psychoses or the lack of available therapeutic techniques. There is certainly evidence that various factors contributed to the reduction of chronically hospitalized cases. With improved standards of hospital care, a growing number of patients received individual attention. The community became more receptive and tolerant with regard to patients who showed fair, but by no means convincing, degrees of improvement. Modern therapies and social directions brought about tremendous changes in the clinical profiles of schizophrenic states. They reduced the severer modes of negativistic and autistic behavior. Patients became less disturbed and behaved more sociably. The speed with which somatic treatments eliminated the most disturbing symptoms, spared patients the experience of isolation and withdrawal which, by the mere fact of prolonged existence, had contributed to affective deterioration.

To put the unfolding story in obvious terms, one cannot deny the evidence that schizophrenia can indeed be a temporary, a recurring and a progressive disorder. Nor can we overlook that the fate of individual patients could not be prognosticated at any given time. What we call prognosis is still to be made predictively; it is as yet a retrospective statement of fact.

Not only is there evidence that modern treatments have greatly enhanced the chances for improvement and return to social existence; there is also every indication that the attitudes toward schizophrenic patients underwent profound changes. Both treatment and social tolerance of schizophrenic behavior have been effective in speeding up the exodus from the hospital. While mortality has ceased to be a danger and while the more chaotic aspects of psychotic behavior have yielded to therapeutic modification, there remains the distressing fact of total failure in about one-third of all patients. We do not know why these patients remained untouched by the social opportunities and therapeutic approaches which they shared with all others.

SIGNIFICANCE OF PRESENT FINDINGS IN THE LIGHT OF BLEULER'S CONCEPT

What does this analysis of the courses of schizophrenia contribute to an assessment of Bleuler's concept? There is every suggestion of the existence of identifiable groups which are characterized by a high degree of internal consistency. The group of optimal recoveries is one. We can no longer be in

doubt that these schizophrenics enter the hospital with a good prognosis which manifests itself regardless of treatments. These patients did well at the turn of the century; they do equally well today. We cannot entertain the illusion that treatments have increased their number.

The non-recoverable group is another. If we assume that Bleuler's permissive policies reduced the number of pseudo-chronic patients to the lowest possible minimum, we find that his 22% with "severe deterioration" roughly corresponds to the current ratio of most severe cases. These are the patients who remained refractory to treatment. It goes without saying that patients in the last 2 cohorts had every type of modern treatment from the time of admission; chronic patients from earlier cohorts also had the benefit of treatments, though many years later. While this is anything but a clinically homogeneous group, the fact remains that these are the schizophrenics with the most unfavorable prognoses. They consist of patients of various ages who had various types of onset and dissimilar social backgrounds. Thus far, it has rarely been possible to identify them during the acute stages. Considerable evidence supports the assumption that internal factors account for the fact that modern treatments remained here as ineffective as did Bleuler's clinical management. To put it differently, it may have taken us more than 30 years to separate the pseudodeteriorating patients from those who, to all intents and purposes, lack the capacity to react with any degree of improvement.

These 2 groups represent the extremes. There remain the groups with various courses of multiple relapses and improvements. We are dealing with schizophrenics with varying degrees of adaptive capacities, some establishing lasting states of functional compensation, others drifting into chronic states of illness. These groups have little but multiple admissions in common. External factors of every variety—social, economic, familial—seem to contribute considerably to reinforcement or disintegration of these patients' ability to carry on.

The existence of the two extreme groups supports Bleuler's concept of the schizophrenias. What significance we attribute to their characteristics, remains a matter of interpretation. It is not the purpose of my presentation to draw conclusions. What I am trying to develop concerns the potential significance of Bleuler's concept for future research on schizophrenia. The inescapable fact before us is this: no decisive new contributions to our knowledge in schizophrenia have been made in recent years. The schism between the protagonists of psychological and somatic concepts continues. Notwithstanding highly sophisticated formulations of psychodynamic, interpersonal and psychobiological frames of references, the notion of schizophrenia as an entity persists. On purely theoretical grounds, this will be denied by many. *De facto,* conceptual references continue to be to schizophrenia, not schizophrenias. This is as true in the laboratory as in the clinic.

Whether one believes in natural or spontaneous courses of schizophrenia is unimportant. What matters is whether or not every scientific effort is made to ascertain what happens to schizophrenic patients. Aprioristic concepts are obstacles to scientific progress. If, as I see it, Bleuler's concept appears as valid today as it seemed valid to him in the beginning of this century, further advances in knowledge may well have been retarded by the notion of schizophrenia, or even the schizophrenic patient, as a uniform object of research and treatment. On the other hand, should the consistently different courses, as they manifest themselves in the groups, be interpreted as social artifacts on whatever grounds, they must be proved to be artifacts. Thus far, they have generally been ignored.

The implementation of the group concept into clinical and investigative methodologies would quite certainly bring about constructive changes in the identification of research targets. Incidentally, acceptance of the group idea could prove therapeutic with regard to the prevailing manic-depressive outlook which, time and again, seduces us to throw off the gloom about an allegedly hopeless disease by swinging into the realm of euphoric overexpectations whenever a new treatment or theory presents itself. Acknowledgement of the actual development in the lives of schizophrenic patients demonstrates that

the evidence of social adaptation becomes increasingly convincing. It would be tragic, however, if the ideal goal of reconstructive psychotherapies should lead to premature belittling of social recoveries. As of now, Bleuler's philosophy of returning patients to normal social surroundings, still appears to be our most effective therapeutic tool.

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A STUDY OF CASES OF SCHIZOPHRENIA TREATED BY "DIRECT ANALYSIS"[1]

WILLIAM A. HORWITZ, M.D.,[2] PHILIP POLATIN, M.D., LAWRENCE C. KOLB, M.D., AND PAUL H. HOCH, M.D.

In the past decade, characterized by the increasing problem of chronic mental illnesses, any method of treatment promising alleviation or cure has been worthy of investigation. In any medical discipline, all new formulations are subject to validation and verification. Any new method of therapy, particularly one claiming cure of an illness known to be chronic with a tendency toward nonrecovery, would be subject to scientific scrutiny. It seems obligatory, in all medical disciplines, to investigate a reported method of treatment and its results, and to determine the extent or amount of change and the temporary or lasting nature of the therapeutic results.

This procedure has been followed in the field of psychiatry whenever any new treatment has been presented. To mention only a few examples, the removal of foci of infection, the use of insulin coma, metrazol and electroshock were all advanced as treatment methods for schizophrenia, all initially, claiming a high degree of therapeutic effectiveness. Subsequent investigations disclosed that in some instances, exaggerated claims had been made. Thus further evaluation placed these treatments in a more proper perspective.

Over the years the staff of the New York Psychiatric Institute has pursued a series of follow-up studies investigating the effectiveness of the various therapeutic procedures offered for the mentally ill. The present report represents one such study directed to assess direct analytic therapy in the treatment of schizophrenia over a long term period.

For those of us who may not recall the method and the hopes for it, we shall review the outstanding points in the original presentation.

The major description of the technique was presented by Dr. John Rosen in an article "The Treatment of Schizophrenic Psychosis by Direct Analytic Therapy" in the *Psychiatric Quarterly*, January, 1947. The author stated that in his method of therapy applied in 37 cases of what he termed "deteriorated schizophrenia," he was

> called upon to converse with the patient in the language of the unconscious and to be in a position to interpret the unconscious to him at every single available opportunity.
>
> Each symptom, each remark, every symbol must be untwisted, clear down to the earliest ontogenetic and even philogenetic roots in the unconscious. Only when the symptom is so clearly unmasked to the patient that it will no longer serve its purpose, will he be able to relinquish it for a more sensible way of handling his instinctual drives. The task is not completed with the resolution of the psychosis and can only be considered concluded when the transference is as completely worked out as we aim to do in ordinary analytic procedures.

This technique required the expenditure of many hours with each patient. For many patients, this required time averaged from 1 to 3 hours daily and in some cases up to 10-12 hours per day. Rosen stated that it was necessary to establish the therapist as a substitute figure of a good parent (either father or mother) to love, to feed and on some occasions to bathe or attend to the patients' personal needs.

By this method of establishing a substitute protective parental figure and interpreting the unconscious directly, Rosen claimed therapeutic results leading to recovery in all 37 cases following treatment from 3 days to 11 months—the average period of treatment was 2 to 3 months.

Recovery was defined in the following terms:

> Regarding recovered patients, let me define 'recovery'. As I use this term, it does not mean merely that the patient is able to live comfortably outside an institution, but rather that such a degree of integrity is achieved that the emotional stability of the patient and his personality and character-structures are so well organized as to withstand at least as much environmental assault as is expected of a

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[1] Read at the 113th annual meeting of The American Psychiatric Association, Chicago, Ill., May 13-17, 1957.

[2] N. Y. Psych. Inst., 722 W. 168th St., New York, N. Y.

normal person, that is, of a person who never experienced a psychotic episode.

Rigid criteria for the diagnosis of schizophrenia were set. Of the original 37 cases reported, all were considered schizophrenic. Quoting from the original article,

> The diagnoses of schizophrenia were in all cases made by physicians other than the present writer, in most cases concurred in by more than one physician. Because the question of diagnosis is certain to be raised by a presentation of this sort, the writer has purposely excluded from this report 4 other cases—also diagnosed schizophrenia by other psychiatrists—but in which he feels the symptomatology was mainly manic-depressive. It has been the aim, in investigating the possibilities of this therapy, to treat initially only patients who were severely schizophrenic beyond the possibility of a doubt. It should be said that the 4 where the writer found manic-depressive features have made apparently complete recoveries also.

In 1952, Dr. Rosen's book *Direct Analysis* was published: here he reaffirmed the original statements in regard to therapeutic outcome. No major modifications of the therapeutic method were described. The status of the original 37 patients was reviewed (p. 95). It was reported that at that time "six were psychotic and probably institutionalized. Of the remaining 31, none was considered psychotic, all were doing well. . . ." It was added that "Those who received a full analysis after the resolution of the psychosis are doing particularly well."

Any therapy that promises so much in the treatment of decompensated schizophrenia unquestionably deserves serious consideration and investigation, particularly if done over a long period of time. At the time of the original report, it was known that many of the female patients had been treated by Dr. Rosen at the New York Psychiatric Institute. We have been able to identify and follow 17 of the female patients of the original series of 37 treated by him while they were at the Psychiatric Institute or after their discharge. We were able also to identify 2 male patients treated by this technique, one a former patient at the Psychiatric Institute, the other a patient of Brooklyn State Hospital (the latter was identified through courtesy of Dr. N. Beckenstein). Thus, we have follow-up material on 19 patients, the other 18 were not available to us.

The follow-up investigation consisted of interviews with each patient simultaneously by at least two members of the Institute staff or interviews under similar circumstances, of the nearest relative, when the patient could not be seen, and social service interviews with the nearest responsible relative at home in instances where neither patient nor relative would come to the Institute. A second source of data was the hospital records whenever patients were admitted subsequently to other mental hospitals. Dr. Malzburg of the New York State Department of Mental Hygiene assisted in the location of some of the patients after their discharge from the Psychiatric Institute. In the more recent follow-up interviews with patients and relatives the material was recorded on tape thus allowing for review and subsequent study.

Table 1 indicates the number of patients followed by the various methods described before:

TABLE 1

FOLLOW-UP CONTACT

Patients interviewed by authors	12
Patients interviewed by social service department	3
Reports obtained from family members	8
Reports obtained from other hospitals	11
Dead	0
Total number of patients located and studied	19

A study of the course of their illness and of the treatment provided the patients after the termination of the original therapy disclosed that 10 of 19 had required some form of somatic therapy: one additionally had a thyroidectomy performed: 4 had psychotherapy only.

Of the 19 patients presented in the original report as schizophrenic by Dr. Rosen, the diagnosis established by the staff of the Psy-

TABLE 2

TREATMENT OBTAINED FOR PATIENTS AFTER INITIAL TREATMENT BY DIRECT ANALYSIS

Somatic therapies	10
Psychotherapy only	4
Direct analytic therapy cont'd.	4
No therapy	1
Total	19

chiatric Institute at the time of the first admission was schizophrenia in only 12 patients. Of the remaining 7 patients, 6 had been diagnosed psychoneurosis, and one manic-depressive.

The follow-up of these 7 cases, shows that their subsequent course was not characterized by repeated hospital admissions. Neither did they subsequently have repeated somatic treatment. One patient in this group of 7, originally diagnosed psychoneurosis by the Institute was twice admitted to a state hospital and on each occasion had electroshock therapy. The state hospital diagnosis in this case was manic-depressive psychosis. This is the only case in this group of 7 that was certified to a hospital and the only one that had any subsequent treatment other than psychotherapy. All of the 7 patients in this group are at present out in the community and have been for several years. One patient, who continued her contact with Dr. Rosen for several years has developed from a shy, sensitive, insecure and jealous person to a mature socially functioning individual. She refused contact with us but her husband, a physician, gave a glowing account of her improvement which they both attributed to the "direct analytic treatment." Of the others, in this group of 7, one was unwilling to contact us, one sees her original therapist, (the other 4 expressed themselves as indifferent and uncertain as to what they had achieved from their period of direct analytic therapy). Of these, one feels that she was cured by a later psychiatrist who employed body massage and bromides, one is seeing a chiropractor and feels fine and one after "suffering through" years of psychoanalysis and readmitting herself to our hospital for psychosurgical consideration was cured after symptoms of a toxic adenoma had fully developed and her thyroid had been removed. Thus this group of 7 patients originally considered by the Institue as non-schizophrenic has followed a course similar to that one would ordinarily expect in a 10-year survey of a group of non-schizophrenic patients.

When we survey the 10-year course of the 12 patients considered schizophrenic originally by the staff of the Psychiatric Institute and subsequently by all psychiatrists seen in the next 10 years, the course is remarkably different from that of the previous group. By the time the original report appeared in print (January, 1947), 5 patients had already been readmitted to mental hospitals (Cases 7, 15, 22, 23 and 29). Of the 12 cases officially diagnosed as schizophrenia in the Institute records, 9 have had from 2 to 5 admissions to mental hospitals during the past 10 years. Two have undergone psychosurgery and another has continued to have symptoms sufficiently severe to have requested additional psychosurgical evaluation. More than one-half of these patients in the subsequent history and later hospital admissions, were treated with electroshock, insulin coma, continued psychotherapy and in recent years tranquilizing medication. In this group it is evident that direct analytic therapy by itself failed to lead to any sustained therapeutic result. Of the 12 patients originally diagnosed by the Institute as schizophrenic and in the first report as "chronic deteriorated" schizophrenics, none has attained or sustained the standard for recovery set forth in Rosen's original article.

The details of the varieties of treatment offered are shown in Tables 3, 4, and 5.

TABLE 3

HOSPITAL ADMISSION AFTER DIRECT ANALYTIC THERAPY

Patients readmitted to mental hospitals	12
Total number of readmissions	29

TABLE 4

TREATMENT OBTAINED AFTER INITIAL DIRECT ANALYTIC THERAPY

Continued with direct analytic therapy	4
No treatment	1
Other forms of psychiatric treatment required	14

TABLE 5

OTHER FORMS OF PSYCHIATRIC TREATMENT REQUIRED

Individual psychotherapy (7)	
Psychotherapy only	4
Somatic therapy	10
Electroshock	8
Insulin shock	2
Metrazol	1
Psychosurgery	2
Pharmacotherapy	3
Thyroidectomy	1
Psychoanalysis	0

It must be stated that 10 of these patients are out of hospitals at the present time; 2 are in hospitals; one a post-lobotomy case is unemployed and completely dependent on her mother; one other post-lobotomy patient is semi-dependent, occasionally works, is considered peculiar and odd by the family and her present therapist. Several are housewives and manage with support from their families. Two are making a fairly good adjustment: one who had an acute episode of catatonic excitement has been quite well for 10 years and works as a steno-bookkeeper. Unmarried, she is considered as a "little saint" by the family. Although the family feels "she was cured by the Psychiatric Institute and prayer," the patient wants to forget the hospital and the whole experience and refused to be seen. The other doing well is an "ambulatory" schizophrenic, never sick enough to be admitted to the hospital and had been treated originally in the OPD of the Psychiatric Institute. She is married and has children. She also wishes to forget and refused to be interviewed. Her mother stated that the family feel that the direct analytic therapy was not of assistance. The patient found it necessary to consult another psychiatrist following the direct analytic treatment in our out-patient department.

Of the two male patients one has returned to Brooklyn State Hospital every 3 or 4 years for a course of shock treatment. The other, several years ago received multiple forms of somatic treatment, followed by years of attendance at a V.A. clinic. At present and for the past several years however, he has been married, has operated a gasoline station and requires no further treatment.

TABLE 6

ADJUSTMENT LEVEL

	1947	1957
In hospital	5	2
At parental home	?	2
Dependent—not working	?	1
Employed at home	?	8
Employed out of home	?	6
		19

In summary, this group of patients has failed to show any outstanding therapeutic response. The several instances of fairly successful adjustment are compatible with the ordinary reactions seen in the absence of specific therapy. The other less successful adjustments are also consistent with the usual course of untreated schizophrenic patients.

The findings in our 10-year follow-up study of the course of these 19 patients fail to sustain the originally reported statement of therapeutic effectiveness of direct analytic therapy in schizophrenia. Many of the patients who at the time of the original report were improved, subsequently relapsed and required other treatments. Whatever the merits of direct analytic therapy for schizophrenia, the claim that it results in a high degree of recovery remains unproven.

FURTHER EXAMINATION OF DIAGNOSTIC CRITERIA IN SCHIZOPHRENIC ILLNESS AND PSYCHOSES OF INFANCY AND EARLY CHILDHOOD[1]

J. LOUISE DESPERT, M.D. AND ALBERT C. SHERWIN, M.D.[2]

The purpose of this paper is to re-examine diagnostic criteria of psychoses of infancy and early childhood, with special emphasis upon schizophrenia. This would seem timely because diagnostic criteria for these conditions at present appear to vary from school to school and place to place(2, 3, 7, 13, 15, 17). A suggested system of distinguishing between the various types of psychoses will be offered, and features of special prognostic significance will be discussed.

Although the concept of schizophrenia in childhood has met with opposition since some of its early formulations(22, 16, 6, 13), more than one observer has recently commented on how freely many psychiatrists, pediatricians and neurologists now make this diagnosis in any child displaying psychotic features in the absence of neurological signs (8, 13, 18). Some formulations like those of Bender[3] seem so broad as to permit the inclusion of cases with suggestive structural etiology, which would in adult psychiatry contraindicate such a diagnosis. Sometimes the diagnosis of autism may be made in cases where autistic symptoms are indeed evident but where the picture fails to meet Kanner's original criteria.

Mahler's formulations of a symbiotic type of schizophrenic illness in young children (17, 19), as differentiated from an autistic type, is oftentimes difficult to apply in terms of clinical diagnosis.[4] Mahler of course states that in the later stages, the two pictures tend to become less distinct, and Hirschberg and Bryant point out that "a child who uses predominant symbiotic defenses at one period may adopt autistic ones at another"(10). In the authors' experience, even in the early stages, clinical pictures are often so mixed that they cannot be said on this basis clearly to belong to either group. Certainly clinical experience does not support a hypothesis, that all schizophrenic children not belonging by virtue of time of onset to Kanner's group belong to a clear symbiotic group.

We are not completely in disagreement with those who tend to describe infantile psychoses in terms of broad concepts of atypical development(15) or deviated ego functions(3), preferring to side-step the question of schizophrenia. The exception

[1] Read at the 113th annual meeting of The American Psychiatric Association, Chicago, Ill., May 13-17, 1957.

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[3] "A clinical entity, occurring in childhood before the age of 11 years, which reveals pathology in behavior at every level and in every area of integration or patterning within the functioning of the central nervous system, be it vegetative, motor, perceptual, intellectual, emotional, or social. Furthermore, this behavior pathology disturbs the pattern of every functioning field in a characteristic way. The pathology cannot therefore be thought of as focal in the architecture of the central nervous system, but rather as striking at the substratum of integrative functioning or biologically patterned behavior." (1942) (1) "We now define childhood schizophrenia as a maturational lag at the embryonic level in all the areas which integrate biological and psychological behavior; an embryonic primitivity or plasticity characterizes the pattern of the behavior disturbance in all areas of personality functioning. It is determined before birth and hereditary factors appear to be important. It may be precipitated by a physiological crisis, which may be birth itself, especially a traumatic birth. Anxiety is the organismic response to this disturbance which tends to call forth symptom formation of a pseudo-defective, pseudoneurotic, or pseudopsychotic type . . ." (1955)(2).

[4] Mahler defined symbiotic infantile psychosis as a psychosis "in which the early mother-infant symbiotic relationship is marked, but does not progress to the stage of object-libidinal cathexis of the mother. The mental representation of the mother remains, or is regressively fused with—that is to say, is not separated from the self. . . . As soon as ego differentiation and psychosexual development confront the child and thus challenge him with a measure of separation from and independence of the mother, the illusion of the symbiotic omnipotence is threatened and severe panic reactions occur. . . . Restitution in symbiotic psychosis is attempted by somatic delusions and hallucinations of reunion with the narcissistically loved and hated, omnipotent mother image, or sometimes by hallucinated fusion with a condensation of father-mother images . . ."(17).

which we take is that this leads again to the inclusion of cases into one large category which may well represent several different types of illness processes. Also we continue to believe that there is such an entity as schizophrenia in early childhood.

As one reviews the kinds of cases of psychoses of infancy and early childhood variously named as schizophrenic, atypical, autistic, or symbiotic, the feature of an autistic defense appears present to some degree in all of them. Autism does not refer to a simple withdrawal. Bleuler originally described it as "a detachment from reality. . . . A peculiar alteration of the relation between the patient's inner life and the external world, (wherein) the inner life assumes pathological predominance."(4) Associated with the autism is a disturbance to some degree in communication, which generally appears to be a refusal to communicate. But Bleuler did not group the various schizophrenias together on the basis of autism or autistic thinking, important as he considered these features to be to the schizophrenic process. Indeed, in a discussion of autistic thinking, he described the latter as present to some degree in normal individuals(5).

In the opinion of the authors, the grouping together of otherwise diverse syndromes occurring in infancy and early childhood on the basis of autistic features alone is, at the present stage of our understanding of these conditions, inadequate and therefore unjustified. It is possible and advisable, in our opinion, to distinguish syndromes of early infantile autism, schizophrenic illness, and psychoses in mentally defective children from each other. It is especially important to distinguish the latter group from the other two, since the possibility of a structural basis is very great here, and may well exist, in the absence of definite neurological signs (for example, a cerebral a—or dysgenesis). It is also necessary to distinguish Kanner's group from the schizophrenias, since the probability of determining constitutional factors is particularly strong here, the predisposition to anxiety extreme, and a dysfunction even to the possibility of organic factors not yet excluded by post-mortem study. In addition, of course, there are psychoses which represent affective reactions, which although rare in this age group, may occur and should be distinguished as such. The degenerative and epileptic psychoses will not be considered and are generally more clearly recognized.

The following case histories may serve to illustrate 3 principal types of psychoses seen in this age period (and often grouped together), with their distinguishing features.

CASE HISTORIES

Case 1.—Male child first seen at age 4 years and 1 month. Picture dominated by autistic behavior and rigid adherence to established routine. Eldest of 3 children. Normal full-term delivery. No major feeding difficulties. Smiled at 6 weeks and in response to mother. Enjoyed being picked up, with anticipatory response and appropriate posture. Alert to environment, and sensitive to noises. Following mother with eyes from 3 months. At times appeared "phlegmatic," at other times cried excessively at small frustrations. Crib biting and rocking during first year. Sat at 6 months, stood at 10 months and walked at 1 year. Sister born at his age 15 months. From this time, gradual diminution of interest in environment and people. Solitary play, interest in lights and music. Severe and frequent temper tantrums. From age 2, insistence upon sameness of routine, changes in which precipitated tantrums and panic. Vocal sounds during second year. Isolated words or phrases at 2½, coincident with sister's learning to talk. For next year did not use words to communicate, or form sentences. Mimicked or talked to self unintelligibly. Continued, however, to enjoy fondling by parents, responding with embraces. Just before age 4, began to communicate requests with words or phrases and occasionally formed sentences. Still responded to most questions by ignoring or repeating. Stanford Binet I.Q. of 89 at this time. Patient's mother, age 27, detached, attractive, intelligent and college-educated, with artistic ability. Her father said to be alcoholic and to have had psychiatric hospitalizations with question of schizophrenia. Her older sister has child treated at another center with diagnosis of "mildly atypical" condition. Mother describes phobic symptoms during childhood. As adult, characteristically accepts situations with resignation and detachment. Father, age 30, a Guatemalan, from wealthy family. Had unsuccessful career as artist and businessman. Has not been self-sufficient and requires help from parents. Has received two courses of psychotherapy for a "character disorder." Younger sister and brother apparently normal.

On examination at 4 years and 1 month, patient appeared intelligent, well-developed and attractive looking. Repetitive drawing of traffic lights, play with any objects which could be made to represent traffic lights, intense insistence on sameness of routine, and limited responsiveness. Most of speech inarticulate or incoherent and did not seem intended for communication. Seen twice a week over a 2-

year period in play therapy. Changes noted have included development of useful and communicative speech. Was able early to express warmly and verbally feelings of affection for and anger at therapist. Play activities expanded, becoming generally appropriate, although some repetitive and perseverative play continues. More responsive at home where he now communicates freely, plays with siblings, and with mother. Satisfactory adjustment to nursery school and recently kindergarten. Writes and draws well, interested in numbers and arithmetic. Now tolerates many changes in routine, and tantrums less frequent. No increase in demands upon or clinging to mother, therapist, or to other individuals. At times of stress reverts to autistic defenses, becoming silent or incoherent, returning to solitary play, bizarre gesturing, ignoring of adults, and passively enduring unpleasant situations. Recent Stanford Binet I.Q. at age 6—108.

DISCUSSION OF CASE

This is a schizophrenic child with onset of major psychopathology essentially after the age of 1½, in the setting of certain traumatic familial situations. His symptomatology included autistic defenses as the outstanding features. There was a disturbance in affective contact with reality, and a thinking disorder characterized primarily by an overdeveloped fantasy life which the child could not properly distinguish from the real world, and by occasional incoherence. In addition, an intense insistence on sameness of environment and repetitive and stereotyped play were present. Bizarre gesturing and mannerisms completed the picture. Except for the age of onset, and the more moderate character of the autistic isolation, this picture is like that of early infantile autism. That is, the defenses employed by the child are similar to those seen in Kanner's group, if of less marked severity. With improvement, the autistic defenses became less marked without appearance of symbiotic features, as might be anticipated from literature. In times of stress, the child continues to exhibit autistic manifestations. The history, psychiatric and psychological examinations taken together suggest that communication was not too markedly impaired and in any event it improved somewhat with growth even before therapy. This was an index to his capacity for affective contact as well as his intellectual ability even before intelligence testing could demonstrate the latter.

Case 2.—Five-year-old boy with a history of autistic behavior, uncommunicativeness, intense insistence on sameness of environment, hyperactivity and repetitive and destructive activity. Normal pregnancy and delivery. Smiled in early weeks of life but not necessarily in response to anyone. By end of first year "was difficult to get a smile out of him." Little anticipation at being picked up and appeared to draw back when held. Did not follow mother with eyes. Did not seem alert to or interested in environment. Rocking especially with music towards end of first year. Sleep poor. Selective of and insistent on certain special foods before age 1 but rapid weight gain. Sat at 6 months, stood at 7 months, walked at 10½ months. Brother born around his age 1. During second year hyperactive and destructive. Severe tantrums, unresponsive. Neither permitted nor sought physical contact. Became adept at spinning objects and tearing paper. No interest in toys. Spoke few words at age 2 but only for brief period. Neither words nor vocalizing used for communication. Made known demands by pushing or pulling. Psychometrics at 3½ showed atypical retarded pattern but successes in a few tasks at his age level. Patient's mother, age 38, had been a successful business woman, an active aggressive person, at first openly rejecting the patient whom she could not "control." Described being repulsed by "little boys" since childhood, but thought it would be "good for her" to have a boy. Father a passive, good-natured man, has suffered business reverses in last several years. Both parents had difficulty accepting child's illness. Sister, age 7, brother, age 3, have shown no known psychopathology similar to patient's.

On examination at age 4, appeared out of contact and hyperactive. Spun objects in highly organized ritual. On once-a-week play therapy over 10 months has made some affective contact. Now speaks a few words, expresses self more intelligibly with vocalizing, and is more responsive at home.

DISCUSSION OF CASE

This is a classical example of early infantile autism, both by age of onset and symptomatology. The fact that this child displayed early inability to make affective contact with other human beings or even to perceive them as such, and that his communication almost from the beginning seemed strikingly limited deserves special emphasis. To evaluate the communicative capacity of an autistic child, it may not be necessary to wait until the age of 4 or 5 to see whether he has developed speech(9, 14). Indeed, what we call responsiveness in an infant may represent forms of communication and usually more than just interest in or attention to us. A careful history and examination of the manner in which infantile gestures and vocalizations are used with respect to communication as well as the character of behavior, may give the clue.

Comparison of our therapeutic results in such cases with those who maintain that intensive treatment is essential reveals little difference in the gains thus far.

Case 3.—A. G. is a 2½-year-old boy with a history of limited responsiveness, bizarre behavior including gesturing and hyperactivity, and uneven but subnormal development since age 1. Older of two children. Exposure of mother to German measles during pregnancy with gamma globulin immunization and no clinical symptoms. Normal delivery. Smiled around age 3 months. Good anticipatory and postural responses to picking up. Sat at 5-6 months, crawled at 9 months, walked at 12 months. Fell from table to floor at age 2 months without unconsciousness or known sequelae. At age 6 months had herniorrhaphy with general anesthesia without known complications. Just before first birthday, visiting grandmother claimed child was "dreamy" and unresponsive, not sufficiently alert. Father sick in hospital for 2 months when patient was 16 months old. In next 4 months baby started rocking, mouthing of objects, was resistant to teaching. At age 19 months a psychiatric examination revealed no functional play with toys, special interest in feeling textures, few sounds, hyperactivity. Finer movements at about 10 month level. He was said to respond emotionally and physically to mother when held in her arms, would also embrace father. At 22-23 months, he was jumping up and down, endlessly making noises, appeared to relate better, was more agile. At just over 2 years, he would respond to bye-bye by going to the door, or bath by climbing into wet or dry tub. No speech except occasional "hi" when greeting father. In next 6 months, some increase in agility and little else. Throughout it has been noted that changes in routine and environment have been well tolerated. Patient's mother anxious, overpermissive and oversolicitous of child. Father professional man, seems closer to patient than mother.

On our examination at age 2½, looked dull, jumped up and down a great deal, vocalized, gestured with hands. Climbed into lap of therapist, embraced him, responded to singing like small infant. Activity primitive and unorganized with no functional play. At times disregarded examiner, at other times sought and showed affection and physical contact. Neurological examination negative. Psychological examination showed atypical but retarded pattern with no area of normal functioning. On once-a-week play therapy over 4 months has shown increase in awareness of therapist, seeks and demonstrates affection, looks him in eye and smiles, but continues primitive and unorganized behavior. Responsiveness at home has increased, has used a few words and many sounds for communication, has been more manageable, and greets father warmly.

DISCUSSION OF CASE

This psychotic picture can be distinguished from schizophrenia, early infantile autism, and uncomplicated mental retardation. Early infantile autism is ruled out by virtue of absence of early signs of communicative impairment, absence of intense insistence on sameness of environment, absence of evidence of relationship with inanimate objects in advance of social relatedness, and evidence of affective contact with human beings far beyond that usually seen in Kanner's group. As to a diagnosis of schizophrenia, there is little evidence of a real disturbance of affective contact with reality. The autism, as previously stated, is mild. Nor does the child's relationship appear "symbiotic." He shows little clinging and no unusual anxiety to separation from parents, therapist, or anyone else. Of great significance is the overall depression of functioning. His unpredictable responsiveness creates a picture not compatible with uncomplicated mental retardation but nevertheless suggestive of a real mental defect. The etiology is unclear, although the anesthesia at age 6 months deserves special consideration, and resulting brain damage would not necessarily be productive of neurological signs. But the case can be clearly distinguished from early infantile autism and schizophrenia and belongs in a separate group, such as psychosis in a mentally defective child, or psychosis of organic origin, depending or the interpretation of findings.

Discussion

Three different types of psychoses of infancy and early childhood have been illustrated. It may well be that these 3 cases do indeed belong in a common group. Despert suggested, and Kanner agreed, for example, that early infantile autism represented the earliest form of schizophrenia, in which development had not progressed normally from the beginning(12, 13). It has also been proposed that mental deficiency when associated with psychoses in children, may be due to the psychotic process(21). But until our knowledge and understanding of these conditions become more definite, it is advisable that we make careful clinical distinctions based on history and examination.

Diagnostic criteria for early infantile autism were clearly defined by Kanner from the beginning(11). In our opinion, the term autistic psychosis should be used only in reference to this condition, and in accordance with the criteria originally formulated,

which involved an illness with onset almost from the beginning of life. Special emphasis should be given therefore to onset in first year of life, the early disturbances of affective perception and communication, the superior relationship to objects in comparison to social relationship, and the intense and unbending insistence on sameness. Schizophrenia begins later and is characterized primarily by a disturbance in affective contact with reality and autistic thinking (6, 7). The picture is distinguished from the former condition by history (evidence of some degree of normal development having taken place in contrast to early infantile autism) and by examination, where evidence of autistic thinking may be marked but where the degree of autistic isolation is generally milder than that seen in Kanner's group. That is, communication and affective perception are rarely quite so deeply disturbed as in Kanner's group, even though autistic thinking may be extremely marked. Also there may be a wider variety of symptoms, such as symbiotic features, possibly because development has proceded further before onset of illness. But disturbed affective contact with reality and autistic thinking remain the outstanding features of any schizophrenic illness of this age period.

The so-called symbiotic syndrome is frequently associated with the schizophrenic child even though it may not always occur. There is a tendency to regard a schizophrenic child as being at some stated time either primarily symbiotic or primarily autistic in his defenses or symptoms, as if the one defense at a given time more or less excluded the other. Simply because Kanner's children seem to withdraw from physical contact does not mean that a child, who clings and melts into another's arms and body with seemingly little warmth or even recognition, is not autistic. Autism is not defined by the symptoms of early infantile autism. It is probable that the symbiotic child is *less* autistic than most children in Kanner's group, but he is still autistic and gives clear evidence of this, at least in terms of Bleuler's definition. Bleuler, for example, writes that "the autistic world has as much reality for the patient as the true one. . . . Frequently (patients) cannot keep the two kinds of reality separated from each other" (4). Surely this applies as much to the symbiotic picture as to Kanner's. So-called symbiosis is a manifestation different from that generally seen in Kanner's group but all the same, autistic in nature. Whether it represents a higher stage of ego development is in the opinion of the authors not established. The occurrence of symbiotic features in itself, does not, in the experience of the authors, have special prognostic significance even though making contact with the child may seem easier at first. The outlook of the symbiotic child who communicates but little, seems not much more hopeful than severe cases of early infantile autism. Those children in Kanner's group who have done well do not appear necessarily to have passed through symbiotic stages but rather simply to have emerged to some degree from their autistic isolation (9, 14). We are not convinced that an emphasis upon symbiotic features is especially helpful to clinical understanding, or that the concept can be effectively applied diagnostically.[5]

As to the question of when to consider a psychotic child as also mentally defective and to be distinguished as such, irrespective of the occurrence of autism, the following principle is suggested. Psychoses in children with generally retarded motor development or overall depression of intellectual functioning should be classified as psychoses in mentally defective children. This principle should obtain even when an atypical pattern is present but where functioning is still below normal in all areas. An atypical pattern is to be anticipated in a psychotic child, whether truly defective or not, particularly when autism is a feature, and does not rule out the possibility of a true mental defect.

The inclusion of these 3 types of syndromes in an "atypical" group is at times misleading. For one thing, it requires a very careful reading of case histories in order to decide upon the clinical entity described. To say the development is atypical is simply to say it is not typical, not average, or not normal. The number of deviations possible are after all innumerable and may encompass many kinds of pictures, not even all psy-

[5] For an example of the difficulties involved in applying this concept diagnostically, see "Symbiotic Aspects of a Seven-Year-Old Psychotic" by Morrow, T., Jr., Loomis, E. A., Jr. (20).

chotic. It may in any event encompass any and all of the psychoses referred to in this paper.

In these several types of psychoses, there generally exists some impairment of communication. In the autistic child, this impairment may be very great. The prognostic importance of the development of a useful speech by the age of 4 or 5 in these cases has already been demonstrated(9, 14). In younger children, the history in infancy relative to early responsiveness, manner of vocalizing, and so on, may be of special significance in evaluating the picture. The schizophrenic child rarely shows communicative impairment to the same degree, and of course it does not extend as far back. In psychoses with evidence of overall mental retardation, communicative impairment may be associated with the mental defect as well as the autistic defense. The extent of communicative impairment represents one useful prognostic indicator for all these types. The usually better prognosis of the schizophrenic child as opposed to the autistic child is consistent with the lesser communicative impairment generally seen. Whatever the impairment is related to in any particular case, communicative capacity probably emerges as the most reliable single prognostic sign in evaluating these psychoses.

Summary and Conclusions

1. With the exception of degenerative and epileptic psychoses, there exists in the literature a tendency to group together psychoses of infancy and early childhood, which may represent different illness processes, or to differentiate between them in accordance with concepts which are difficult to apply clinically.

2. Autistic defenses are generally characteristic of these psychoses. But this does not justify a failure to differentiate between types which can be distinguished clinically. Such differentiation would appear advisable until knowledge concerning etiology increases.

3. It is suggested that the diagnosis of "autistic psychosis" be applied only to cases meeting Kanner's criteria of early infantile autism.

4. The diagnosis of "schizophrenic illness" should be applied to cases with onset after age one and with a picture characterized principally by loss of affective contact with reality and autistic thinking.

5. Psychoses in children with retarded motor development, or in whom intellectual performance, although atypical for any age level, is below normal functioning in all areas, would best be classified for the present in a separate group as psychoses in mentally defective children.

6. With the exception of rarely occurring affective psychoses in this age group, and with the exception of organic and epileptic psychoses, most psychoses of infancy and early childhood will meet the criteria of one of these types. Cases characteristic of 3 types have been presented.

7. The degree of impairment of communication present in these psychoses constitutes a significant prognostic factor.

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DISCUSSION

JOHN A. ROSE, M. D. (Philadelphia, Pa.).—I should like to commend the efforts of Drs. Despert and Sherwin to bring organization to these problems of diagnostic thinking. The focus of the effort is twofold. An attempt is made to distinguish between severe infantile disturbance and retardation of primary nature. The other purpose is to distinguish between severe infantile disturbance in which there is early impairment of object relation and those cases in which the history is that of apparently satisfactory early object connection. It is suggested the former type of case should be categorized as autistic and the latter as childhood schizophrenia.

In a way, it is unique in the history of psychiatric diagnosis to discuss a nosological system in which schizophrenia carries a more benign prognosis than some other entity. One of the points made by the authors is that autism may be the result of constitutional susceptibility and thus less treatable. It would appear to be for this reason that Bender's criteria are rejected as too broadly inclusive; the same being true of the "atypical development" of Putnam and Beata Rank. That is, the childhood schizophrenia of Bender does not allow for psychogenesis of disorder and the atypical development of Putnam and Rank not precise enough to distinguish primary defects in the equipment of the infant.

In considering this entire attempt at better differential diagnosis between cases of severely disturbed young children, I am led to speculate that the attempt is motivated by a problem in the children's field which concerns all who work in it. The fact is that there exists a growing feeling that some of these cases are either irreversible from beginning or become so at the 4 to 6 year level. This, if true, is of great importance to our state hospital systems in its implication for future planning. Children with irreversible mental illness who will be wards of the state from 5 or 6 years of age until they die are a potentially staggering problem. Hence, any attempt to find a group of cases of severely disturbed young children who are still treatable is certainly worthwhile. It is also a matter of considerable import to those of us in commuity psychiatric clinics for children. Such clinics have an obligation to invest limited treatment time in the most useful way possible.

Thus, on several scores there is great justification for an adequate system of differential diagnosis. The case examples cited suffer from a common deficit. The developmental histories were obtained retrospectively. It is our experience with these families that perceptual distortion of the actual development of the child is commonly so great as to invalidate either a favorable or unfavorable picture of the child's earlier development.

The considerable differences cited in the literature on etiology may be considered as arising out of problems in interpretation of developmental histories. There are formidable problems to be dealt with not only as to where the locus of the primary problem exists, but also in the secondary interaction affecting husband and physician. Even in clear cases of birth injury, the mother's ego needs may cause a sympathetic perceptual distortion of facts both by husband and physician. We have observed that irritable states in 2 or 3 month old infants often seem capable of producing extremely distorted views of the current symptomatology.

Some colleagues in discussion have mentioned studies in which much maternal pathology and perception distortion exist, yet no symptoms in the infant are objectively discernible.

The confusing permutations and combinations which are possible lead to a conclusion that continued investigative work will be needed to clarify the diagnostic problem. Current projects undertaken both from the anterospective and retrospective viewpoints may furnish data of critical nature for the diagnostic process. If we know more clearly what to look for and how to look, we may succeed in obtaining more consistent developmental histories.

Currently, also, we have a professional problem in description of infant behavior ourselves. A clearly withdrawn child is readily described; it is much more difficult to describe the behavior of a child with atypical object relationship. Interpretation of behavior without inference of purpose is almost impossible. Such description probably would not be helpful even if possible.

It is our hope that current studies will reveal not only better pictures of the maternal disturbance, but also a consistently better idea of the meaning of the behavior of disturbed young children. Until our tools are better, it does not seem wise to design a classification of more precise nature than the methods of obtaining data allow.

I too accept "obsession with sameness" as a diagnostic point in these cases, and suggest it is also possibly a learned activity as well as serving as a defense against anxiety. We have seen several cases recently of young infants in which the "sameness" was inherent in the rigid routines developed by the mother as her own defense against tension; under hospital conditions the infant was much more elastic in his choices of food, toys and people than as presented in the picture obtained from his mother.

Such considerations as these move me to praise the authors for their thoughtful analysis of available data, but urge that the distinction made is not sufficiently helpful at present. I do not believe the distinction will be sustained when more data are available.

THE MISUSE OF THE DIAGNOSIS CHILDHOOD SCHIZOPHRENIA [1]

HILDE L. MOSSE, M. D.[2]

There has been an enormous increase in the diagnosis of childhood schizophrenia. We find an ever larger number of cases both in the psychoanalytic and general child psychiatric literature(1, 2, 5, 7, 8, 9, 14, 16). Few cases have been followed into adulthood(1, 7, 13), and where it is reported that the diagnosis was then confirmed, this is still open to question because of the prevalence of confused and inconsistent diagnostic criteria also in adults(3).

Schizophrenia is not a disease of childhood. Its onset is in adolescence and preadolescence. Studies of childhood behaviour of definite adult cases of schizophrenia(4, 19) show that they are, as a rule, model children, inconspicuous, and quite different from the cases described as childhood schizophrenics.

Child psychiatry is still in the pre-Kräpelinian stage. No valid classification of mental diseases in children has yet been worked out. For the study of schizophrenia in childhood we have to take into account the progress made since Kräpelin and Bleuler in the refinement of diagnosis. This progress has been in two main areas, in the sifting out of other diseases, and in the development of tests.

The development of tests has given a new dimension to psychiatry. We have found the Mosaic test as interpreted by Wertham(23, 25, 26) so helpful for the diagnosis of schizophrenia, that we feel no child should be diagnosed as suffering from schizophrenia without a schizophrenic Mosaic design. Some workers(6) found a 100% correlation between definitely diagnosed adult cases and their typical mosaic.

The present trend to diagnose children with severe emotional and mental symptoms as schizophrenic is scientifically wrong and has had serious practical consequences. It has filled state hospitals and schools for mental defectives. Children in trouble for many different reasons are now likely to be so diagnosed.

We have studied 60 such cases below the age of 14 at the Lafargue Clinic and in private practice. In practically all of them the diagnosis was wrong.

Seven-year-old Bernard is representative of the many cases where unnecessary hospitalization and harmful treatment followed this wrong diagnosis. His mother took him out of the hospital and brought him to the clinic. She said: "He had only 6 shock treatments, not the full 20. He had forgotten even our dog's name when he came home, and he had known him since the dog was a puppy. It was just like he had to learn all over again. It seemed like he was in a daze most of the time." Clinical examination, tests, playgroup observation showed no evidence of schizophrenia. Our diagnostic task was made even more difficult because of the symptoms and the changes caused by ECT. It is exactly as Dr. Nolan D. C. Lewis stated: "The thing that interferes with using diagnostic intuition more than anything else is shock therapy"(15). This boy recovered with group and individual therapy.

The most pressing unsolved social problem in the United States today as far as children are concerned is that of juvenile delinquency. A child who commits a crime is now likely to be diagnosed schizophrenic and sent to a mental hospital. This puts the problem into a wrong focus, namely into the field of mental illness of unknown origin inherent in the child, instead of into the field of social pathology to which the child is reacting.

George is such a case. He came to the clinic in 1946 because of a severe reading disability and truanting from school. He was the leader of a gang of about 30 boys and feared that a member of a rival gang might stab him in school. When he came to the clinic he brought two body guards who kept watch at the entrance. His gang became involved with the killing of a policeman, and he was arrested and sent to a mental institution where he made 3 suicide attempts before his final commitment to a state hospital where he made another suicide attempt. The diagnosis was schizophrenia. He was discharged once but recommitted after an arrest for fighting while drunk. He was then sent directly to the mental hospital and not to jail because of his previous stay there.

I visited him in the hospital when he was 22 years old. I found him friendly and outgoing. There were

[1] Read at the Second International Congress For Psychiatry, Zürich, 1957.

[2] From the Lafargue Clinic, New York.

no delusions or hallucinations. He gave a coherent account of his past life inside and outside the hospital. He attempted suicide because he was depressed. He worried about the other boys in his gang some of whom were in jail awaiting trial for their life. He told me: "I was the baddest boy on the ward. There were boys from another club and we got to fighting. I was all confused. I heard boys hollering, screaming. You get to thinking about it when you are alone by yourself, you shouldn't have done this, you shouldn't have done that."

This is not what patients tell us after an episode of "catatonic" excitement. The doctor in charge told me he did not think that George had schizophrenia. Many boys now on the wards of this and other hospitals got into trouble because of gang membership and are not psychotic.

Our case material shows that symptoms are frequently misinterpreted. This has serious consequences for the child's entire future life.

This happened to Robert, age 9. He was sent to a mental hospital for truancy, running away from home and stealing. The diagnosis of childhood schizophrenia was based primarily on the following factors: "On occasion he thought people were following him and was compelled by some introjected body to do things like steal and stay away from home."

Here delusions of reference are implied but not proven, especially when we take into account that such a serious symptom never occurs only "on occasion." Our cases show that the so-called introjected-body-delusion is most often a fantasy and represents a conscious or unconscious rationalization for forbidden actions. Frequently children tell us: "a voice told me to hit him" or "the devil told me to kick her." The child may consciously want to show that he is not responsible for the bad things he does. Some children grow up in an environment where the devil is considered a reality, and forbidden deeds and thoughts are explained by the devil having entered the person. Some children we see have been told that spirits exist, can come to life, talk to people and influence them. Actually, Robert had run away from home because of a cruel mother and stepfather. He stole money because he needed it. Our clinical examination, tests and playgroup observation showed no evidence of schizophrenia. He was rehospitalized against our advice. He was given 20 ECT. After these he became: "agitated, felt that his body had been mutilated, played with words, shouted, ran about, was overtalkative and appeared to have feelings of unreality." This iatrogenic syndrome then lead to his committment to a state hospital.

The sequence in this case is typical. The child misbehaves in school and often, not always, also at home. He can no longer be kept in the class room. His parents are advised to take him to a hospital for observation, or they are referred to clinics, agencies or the children's court. There it is felt that the child is suffering from childhood schizophrenia, and he is sent to a hospital where the diagnosis is confirmed and he receives 20 ECT. The child may react the way Robert did and be committed to a state hospital, or the parents may take him home with or without the doctor's consent. Most of the children we have seen were then not able to function in the community. They either had to be exempted from school for some time and eventually improved with psychotherapy (if this was available to them), or they had to be recommitted soon. After a stay in the state hospital for anywhere from several months to 4 years, they are discharged with the diagnosis changed to "behaviour disorder." This change of diagnosis is so frequent that it has become the rule rather than the exception. So it happens that in an entire caseload of one social worker only one case was discharged with the original diagnosis of schizophrenia.

Some cases are sent not to state hospitals but to state schools for mental defectives. In one state school 95% of children sent to them as childhood schizophrenics turned out to be grossly organic cases, for instance encephalitis, definitely not then certifiable as childhood schizophrenia. Franz Kallman has made similar observations in his study of twins.

We had the opportunity to examine children at different stages of this sequence, either inside or outside the hospitals. Among our cases are children with psychologically caused conditions. We have searched the literature and were unable to find even one fully analyzed and definite case of schizophrenia in which the causative connection

between early or later infantile psychological trauma and the disease was really established scientifically. Children may react in a bizarre way to severe trauma but that does not mean that they then have schizophrenia or will develop it later on in life.

Our material contains organic cases such as epilepsy, epileptoid mood disorder, encephalitis, mental deficiency, endocrine disorders and developmental disturbances. We have found that even mild forms of agnosia, apraxia, aphasia, impairment of auditory perception and dyslexia may cause severe learning and behaviour disturbances and lead to the erroneous diagnosis of childhood schizophrenia. Schizophrenia is not an organic disease in that sense. We know it is a progressive disease, but we do not yet know where the schizophrenic process takes place. Wertham's conclusion in *The Brain As An Organ* is still valid(21):

> On the ground of anatomical facts, there is no justification for speaking of an "organic cerebral process" in schizophrenia . . . there is, today, no histopathology of this condition. To draw from this negative statement the conclusion that of necessity schizophrenia can not be due to any organic factors, and must consequently be of psychogenic origin, would be hasty and unwise.

One of our most difficult diagnostic tasks was to differentiate cases of schizoid psychopathic personality. These have mild, chronic, non-progressive symptomatology but may have severely disturbed episodes.

Genuine paranoid delusions have not been described in children. We have observed a type of hostility which may be malignant and possibly a forerunner of delusions. This problem comes up in the very large number of cases referred to us with the chief complaints of: "Hits other children without provocation, is a menace to the safety of other children in his class." We then have to find out whether he hits other children because he is attacked by them and has to defend himself; because he is so anxious and insecure that he feels it is safer to hit first because he thinks they are going to hit him anyhow; because he imitates strong man figures he admires such as Superman; or because we are really dealing with a morbid, possibly schizophrenic suspiciousness and hostility.

One of the most important gaps in our knowledge is that the limits of normal for children of different ages have not yet been established. In neuropathology many findings which were once called abnormal are now known to belong to the "extent of the normal"(21). We may find this to be true also in child psychiatry. How far in degree and in terms of a child's age can magic thinking go before it can be termed pathological? When should a dreamy child be diagnosed as pathologically withdrawn? Up to what age, in what type of child and to what degree is fantasy preoccupation compatible with mental health? This brings up the question of visual and auditory hallucinations. It is known that children normally have more vivid auditory and visual experiences than adults. They have to learn to distinguish fantasy from reality. Stories, especially in comic book format, on television and in the movies, are taken seriously and carried over into play, daydreams, dreams and projected into tests(17, 18, 24). During episodes of anxiety and especially before going to sleep many children experience visual, tactile and auditory fantasies which they may feel come from the outside and about whose reality they may not be quite certain. Piaget has found that until about the age of 9 a child may believe a shadow is a substance; it is therefore not surprising when a child reacts with fear when he sees shadows. The error is often made that such experiences alone are regarded as symptoms of a serious and malignant disease. The fact that most children have a positive eidetic disposition(22) has to be taken into consideration also. Several of our cases were committed on the basis of such symptoms which are really within normal limits.

> John's diagnosis was based mainly on: "visual hallucinations." He described the following: "I just close my eyes and I see elephants. Sometimes when I imagine things I can see it. I have to have my eyes closed. Sometimes I see cowboys. I make myself one of them. They do whatever you want them to do. Sometimes when I can not sleep I do it. Then I'd go to sleep."

What this boy described is what Dr. Jellinek has called "spontaneous imagery"(11, 12). It is not a pathological phenomenon and seems to be easier for children to produce than for adults.

Our cases include neuroses. They bring

up the interesting problem of differentiation between schizophrenic regression and neurotic fixation. Their prognostic evaluation is made especially difficult because some adult cases of schizophrenia have neurotic traits in childhood. The Mosaic test is here particularly helpful(23, 25, 26). With its aid we can also distinguish cases of obsessive-compulsive neurosis on an affective basis with good prognosis from those malignant forms which are really symptoms of schizophrenia.

Our cases show how erroneous dogmatic thinking may lead to contradictory therapeutic procedures. Often they are dangerous for the child. At any rate, they deprive the child of constructive social and psychotherapeutic measures. In many cases anti-convulsive medication and then ECT was recommended in the same case within a period of a few weeks. Children of all ages are being subjected to lobotomies on the same basis(10).

Childhood schizophrenia is at present in the United States a fashionable and much abused diagnosis. Careful clinical study indicates that far more often than not this diagnosis is wrong. This is not only a threat to children living in a socially difficult milieu, but also hinders the progress of psychiatry as a science.

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HISTORICAL ROOTS OF PSYCHOTHERAPY[1]

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If psychotherapy is to be considered as any procedure or process which changes behavior or influences an individual towards a more adequate or satisfactory adjustment to his environment or encourages peace of mind, then its roots reach back into prehistoric ages. Psychotherapy may be direct, indirect, or entirely unintentional. It may be self acquired and applied, or initiated by others unintentionally, as it must have been in the ancient days through suggestion, persuasion or by identification (or imitation) of the individual with the successful behavior of companions. If whatever occurred modified the behavior of the individual successfully, it was psychotherapy of some sort or order.

If psychotherapy signifies mental healing or attempts in this direction its realm is indeed vast. It includes hypnotism, suggestion, persuasion, education, the various so-called psychodynamic schools, vocational therapy, music therapy, religion therapy, particularly highlighted in the form of Christian Science, and the more recently developed group therapies. It is a fact that from the very beginning of medical practice, especially of psychotherapeutic practice, at least from the time of the Babylonians, the trained professional workers had lay competitors, a situation that still obtains and is growing. Freud once said, "There are many ways and means of psychotherapy. All methods are good which produce the aim of the therapy." We attempt to detect from the earliest written records a trend here and there that can be recognized as having served, or having tried to serve, the individual in some favorable modification of his life situation.

Although there is a great deal of ancient literature bearing on the field of medicine, it is probable that the greater part of it did not survive. The literature of one of the most active and interesting eras in medical history, that is, the three centuries B. C., has reached us only in fragments.

> There is much that has been lost without even a trace. An inscription found by the merest chance tells us of a doctor who wrote 256 books but not a single fragment of these books survives. Considerations such as these will serve to emphasize the need of caution in historical reconstruction based on the fragmentary evidence that we happen to possess.[3]

The practice of psychotherapy is always in keeping in a way with the social setting in which it occurs and Wundt's scheme of the history of culture might be used in this connection to outline the development:

1. The period of primitive man
2. The period of totemism
3. The period of gods and heroes
4. The period of humanity

One should probably assume that some sort of psychotherapy had been practised long before written history. It is known from various ancient sources that in the beginning no distinction was drawn between diseases of the body and of the mind, although special speculations on the nature of mind and thought have been in evidence since the beginning of any civilization. Certainly from the records it is safe to assume that in the childhood of medicine in Assyria, Babylonia, Egypt, India, Judea, Phoenicia, Greece, China, and in the ancient Western Hemisphere, the prevailing concept of disease was centered in some form of demoniacal influence. The physician and the priest were one and the same person as they still are in certain belated or primitive societies where exorcisms are used to drive out the evil spirits as the supposed causes of disease. The physician of today is a direct descendant of the Egyptian, Chaldean and Druidic priests.

As man progressed, the supernatural elements began gradually to give way to more clearly observed facts and history indicates that the ideas of Greek natural philosophers

[1] Read at the 113th annual meeting of The American Psychiatric Association, Chicago, Ill., May 13-17, 1957.

[2] N. J. Neuro-Psychiatric Institute, Princeton, N. J.

[3] I. E. Drabkin, Jour. Med. Education, 32: 286, 1957.

formed the first era of modern medicine. Their works demonstrate that they were not influenced by the gods, but searched for truth in other directions. Protagoras said,

> "I can know nothing concerning the gods whether they exist or not for we are prevented from gaining such knowledge not only by obscurity of the thing itself but by the brevity of human life."

However, he did not come out too well personally since he was driven out of Athens as a reviler of gods and his books were burned in public. It has never paid to be too far ahead of your contemporaries. Chilo's "Know Thyself" inscribed in the Temple of Delphi which Socrates considered the only object worthy of man, and the maxim "Man is the measure of all things" first uttered by Protagoras seem to be a starting point in Ionian philosophy from which the historian may proceed along the trends that lead directly to modern psychotherapy. Protagoras, the Sophist who lived in the 5th century B. C. considered man to be the most helpless of all creatures, and the only weapon he has to combat the multitude of dangers confronting him is his mind.

Celsus in the Christian era advocated 2 widely divergent methods of therapy for the mentally ill. On the one hand he had a use for starving and flogging because he said those who have refused food start to eat and in some cases the memory is refreshed. On the other hand, he said that everything should be done to divert the melancholiac, and advocated music, reading aloud, swinging in a hammock, sports, and pleasant surroundings.

Coelius Aurelianus (400 A. D.) placed the patient under the best conditions of light, temperature and quiet, and recommended that everything of an exciting nature should be excluded. Of particular note are his references to tactfulness on the part of attendants, for the avoidance of antagonisms and to the limited and cautious use of physical restraint. He thought the physician should not see the patient too frequently, lest his authority become undermined. Theatricals, entertainments, riding, walking and work were all recommended, particularly during the period of convalescence. Topics of conversation were to be such as would suit the patient's condition. He also made the pronouncement that no philosopher had ever been able to cure completely a patient with mental trouble. Galen who contributed so much to early medicine, did very little for psychotherapy as such but worked almost entirely with the physical and drug therapies of the time.

Dream interpretation for the relief of anxieties and fears as well as for prophesy is at least 2000 years old as is found in the writings of Plutarch, the great biographer of ancient times. His reports of dream interpretations are very interesting.

Paracelsus (1493-1541) formulated a doctrine of mental disease with psychic causes and advocated body magnetism which later became mesmerism and still later hypnotism, and Spinoza, the brilliant philosopher of the 17th century, anticipated many of the concepts that Freud later discovered and developed through clinical experience, but the foundation for modern psychotherapy was laid toward the close of the 18th century by Mesmer's "magnetism." His graduation thesis from the University of Vienna in 1766 was entitled "On the Influence of the Planets on the Human Body." His views were a mixture of the known physiology and the astrology of the times. Some investigators have claimed that Mesmer really expressed ideas that he had gathered from Paracelsus and from a Scottish physician, William Maxwell.

Since I have stated that the foundation or roots of modern psychotherapy is to be found in Mesmer's pioneering ideas we shall look a little closer at what happened there; although the story is familiar to most of you, there are some points deserving of emphasis in my particular topic. Mesmer believed thoroughly in the genuineness of his discovery and after years of outstanding success he attempted to gain recognition from the Royal Medical Society and the Paris Academy of Science, but the members of the scientific committee appointed by Louis XVI in 1784 to investigate the matter reported that cures were genuine but were due to the imagination or imitation in the patients and had no scientific basis. This was exactly

Mesmer's idea, that people influence each other just as the magnet influences iron filings, that is, they either attract or repel each other. It is of some interest that the famous Lavoisier and our own Benjamin Franklin were members of this investigating committee. This scientific committee made no effort to inquire into the nature of this imagination and imitation which apparently caused cures and Mesmer died about 30 years later in obscurity. He actually laid the foundation for hypnotism and other forms of suggestion as well as other types of psychotherapy which began a century later.

Some have advocated that Mesmer was a conscious charlatan but this is doubtful. He was probably given to a bit of showmanship and dramatic flairs, a tendency from which some of our own contemporaries are not entirely free, but withal Mesmer believed in his theories and in their efficacy in therapy. The Marquis de Puysigur first discovered somnambulism. He noticed that some subjects spoke and acted during the hypnotic sleep as if they were aware of what they were doing but retained no memory of their actions. He said, "They have acted as if in a dream." In 1815 a Portuguese, Abbi Faria, showed that certain individuals are so sensitive and impressionable that they go to sleep upon a positive command to do so, thus demonstrating that Mesmer's manual or magnetic contact was not always necessary. A number of English surgeons used Mesmer's technique in practice and one of these, James Braid, called the phenomenon "hypnotism," since sleep was the most important factor rather than Mesmer's magnetic fluid theory.

Johann Christian Reil (1759-1813), professor first at Halle then at Berlin, in addition to demonstrating that parts of the brain controlled certain parts of the body, in 1803 wrote a book, *Rapsodieen*, on mental treatment (psychotherapy) and in 1805 founded the first journal for mental disorders. Jean E. D. Esquirol (1772-1840), the successor of Pinel at the Salpêtrière in Paris, organized 10 mental hospitals. He advocated the utilization of the colony system for the mentally ill and a boarding out system for suitable mental patients requiring prolonged supervision. In 1821 he visted the celebrated village of Gheel in Belgium where for centuries it had been the custom to board out patients but where no physician had previously investigated these possibilities. Subsequently by his initiative in 1832 the first colony for the mentally disordered was organized in the suburbs of Paris. It was called the "Farm of Saint Anne," and later it became famous and served as a model along these lines.

The first systematic reactions against a mechanistic and static attitude in psychological medicine developed in France where interests in purely mental phenomena were not considered as a regression into medieval superstitions. In Nancy, Bernheim (1840-1919) and Liébault (1823-1904) developed a center for research in hypnotic phenomena. The former published his book *Hypnotism, Suggestion and Psychotherapy* in 1891 which represented the scientific attitude and application of hypnotism. He, with Liébault, demonstrated the phenomenon as due to suggestion for which verbal stimuli could be substituted for sensory stimuli.

Although Charcot the famous neurologist had paved the way for modern directly applied psychotherapy, previous to 1900 there were no physicians specializing in psychotherapy and calling themselves psychotherapists as far as I can find. The word "psychotherapy" as such was not generally known or at least it did not appear in such psychiatric works as Clouston, Weygant, Bianchi or White.

The English translation of Dubois' *The Psychic Treatment of Nervous Disorders* was published in 1905 by S. E. Jelliffe and W. A. White. Dubois was not in favor of hypnosis. He said,

> The psychotherapy, which I call rational, has no need of this sort of preparatory narcosis or hypnosis, or of this hypersuggestibility that is itself suggested. It is not addressed to an impressionable polygon, but simply to the mind and the reason of the subject the psychic therapy is indicated in all the affections in which one recognizes the influence of mental ideas, and they are legion.

Dubois was also opposed to re-education since it involved the influence of authority, suggestion and suggestibility, all of which he asserted were of only temporary effect, and

were probably detrimental in the long run. Therefore he says,

> I recognize but one means of education, persuasion by means of proof by demonstration, by logical induction and by reason which touches the heart. Of the proof of this last means there are all degrees. Precise, but cold proof dispenses with every emotional outlet. It appeals only to reason.

Dubois rejected hypnotism because of authoritative aspects while Freud ceased practicing it mainly on the basis that it did not afford insight into the origin and meaning of the symptoms.

It is usually conceded that the psychology of hypnotism and other forms of suggestion was unknown until Ferenczi explained it on the basis of a father-child relationship. If the child has confidence in the father, or a father surrogate, he will obey what is told him. Bernheim, who was an outstanding contributor in the field of hypnotism and suggestion, pointed out that our whole mental life is filled with the phenomena of suggestion. We influence others and they influence us constantly by this means.

The famous Pinel, contemporary of Mesmer, advocated "moral treatment" which was a form of psychotherapy adopted by many of the psychiatrists of the times. From the descriptions, apparently what was known as "moral treatment" was in effect comparable in several respects to modern "total push" procedures since it included psychotherapy, occupational therapy, and recreational therapy. It would seem that the founders of American psychiatry, particularly Pliny Earl who described the moral treatment at the Bloomingdale Hospital in 1845, and Amariah Brigham the superintendent of the Utica State Hospital in New York, who defined the treatment in 1847, from their descriptions were making active applications of psychotherapy along with the various diversions and recreations, lectures, etc. that were afforded the patients. Isaac Ray was also a skilled moral therapist who pointed out the advantages of the moral therapy procedures. One of Earl's favorite means of treatment was formal instruction including various lectures and school exercises in natural philosophy, chemistry, physiology, astronomy; physical, intellectual and moral beauty; poetry, history, etc. to influence the mind. The descriptions of these lectures reminds one of group therapy sessions. They were delivered in the evening and were often attended by as many as 70 patients.

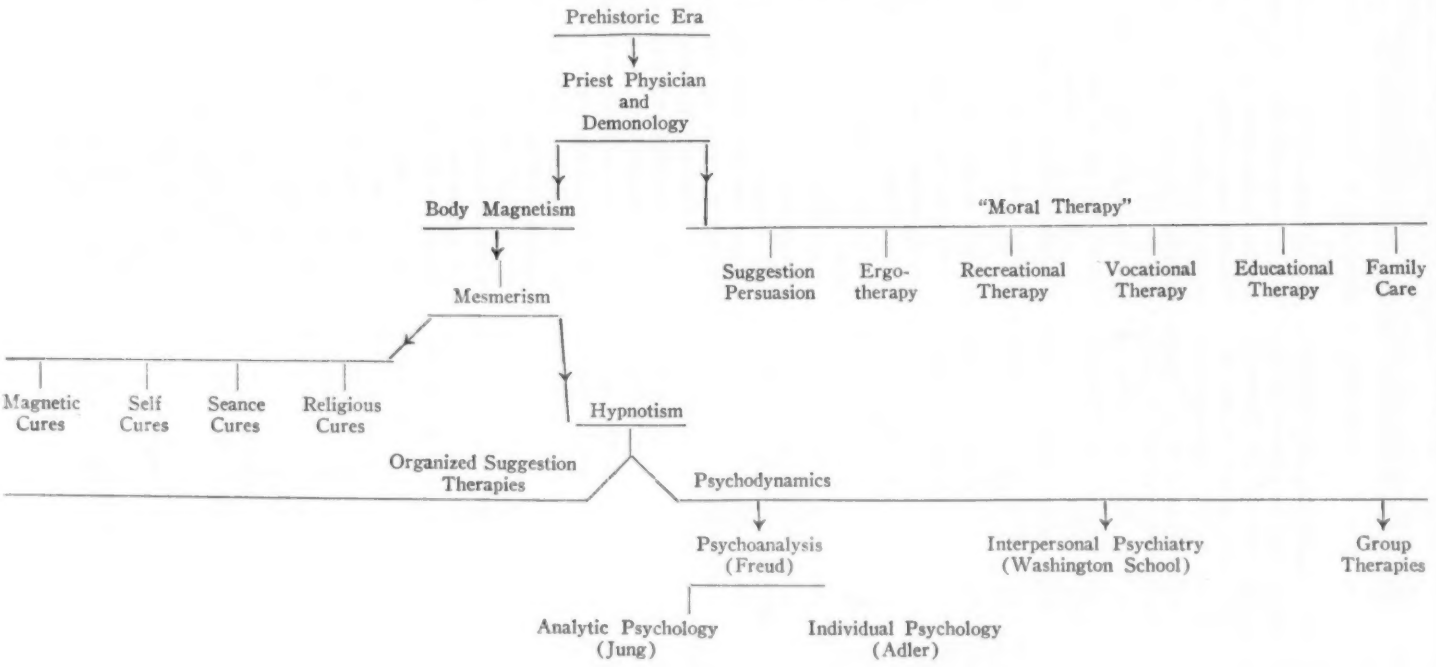
In order to bring the fragments of the origin and growth of psychotherapy into a concise picture, I would say in summary that out of prehistoric times there gradually developed the priest-physician whose activities often involved what became known as demonology. From this now somewhat obscure and diffuse mass evolved 2 trends, namely, bodily magnetism, and the roots of what was later called moral therapy. These were not clearly separate and distinct any more than their derivatives are at the present time but they overlapped and combined in various ways and settings.

Bodily magnetism became mesmerism from which has stemmed directly the organized suggestive therapies and hypnotism which not only is still practiced actively but which fathered and stimulated the creation of psychodynamics as expressed in psychoanalysis (Freud), analytical psychology (Jung), individual psychology (Adler), interpersonal psychiatry (Washington School) and the group therapies.

Not only is modern hypnotism a direct residue of mesmerism but so are: 1. magnetic cures—magnetic belts, Weltmerism, magic charms, etc.; 2. Self cures: Coueism, autosuggestion, "will training," etc.; 3. seance cures: quasi religious and semi-mystical cults; 4. religious cures: Christian Science (a direct offshoot from Mesmer by a disciple Phineas Quimby through Mary Baker Eddy).

The root that one might call moral therapy through the many years has branched into suggestion, persuasion, explanation, ergotherapy, vocational therapy, the various recreational and educational programs, family care and several others that could be mentioned. However, in keeping within the time at our disposal I will leave you with the hope that you will find in this brief sketch the apparent historical roots and some high spots in the course of the growth of psychotherapy.

SCHEME OF HISTORICAL DEVELOPMENT OF PSYCHIATRY



SOCIAL ASPECTS OF PSYCHOTHERAPY[1]

FREDRICK C. REDLICH, M.D.[2]

Research on the relationship of psychiatric treatment to social class by a team of sociologists and psychiatrists at Yale University (2, 7) established that patients in the different social classes of the community receive different psychiatric treatment. The relationship of class to treatment is very definite and stronger than the relationship of diagnostic categories to types of treatment. There are marked differences in 1. referral to treatment, 2. types of treatment, 3. duration of treatment, 4. type of agency and psychiatrist administering treatment, and 5. efforts to rehabilitate the patient. Focusing on psychotherapy, we found that intensive and dynamically oriented psychotherapy is almost absent in the lower classes; this does not mean that such therapy in the lower classes is not possible, it only means that, at least for social and economic reasons, it is carried out rarely and inefficiently. The most general explanation for this phenomenon is difficulty in communication between lower class patients and psychiatrists. In examining this problem further, our attention was directed to a deep split in the practice of psychiatry in our community(6). Although we examined only practice patterns in our community, we believe that careful extrapolation of our findings to other communities may be justified.

We refer to the two practice groups in psychiatry as the analytic-psychological, or A & P group, and the directive-organic, or D & O group. The latter group is often referred to as the eclectic group—a term which we, for various reasons, do not use. Few practitioners are true eclectics, *i.e.* persons who do not adhere to any school of thought and borrow from all schools. There are great and independent minds who do not fall into any group—we prefer to speak of them as individualists—but the great majority of psychiatrists belong to one camp or the other; exceptions are also some workers in the psychosomatic field. This split, we hope, will not last forever, but it exists in mid-century psychiatry in the United States and Canada. We also think that the division into A & P and D & O psychiatrists is more significant than a division into private practitioners and psychiatrists working in hospitals, clinics, administrative and academic positions, although we have noticed that the group of private practitioners of psychiatry has become the group with the highest prestige in the field.

Our division is based on criteria of practice, including its underlying theory, and on the psychiatrist's training. The A & P group essentially practices so-called dynamic psychotherapy and psychoanalysis; its practices are based on current psychoanalytic theories. The emphasis in therapy is on gaining insight into unconscious forces, strengthening the ego through such insight, and enabling the patient to abandon irrational and maladjusted behavior. The techniques are analytic and not directive or manipulative. If directive or manipulative procedures are carried out, they are supposed to be based on analytic insight of the therapist into the patient's ego weakness which requires temporary support, direction and manipulation. The "personality" of the therapist is supposed to be less important for the treatment process than the technique. The approach is almost entirely psychological. Organic methods of diagnosis, such as physical examination, medical and laboratory procedures, are extraneous to it and are, if necessary, carried out by other specialists. Although these A & P psychiatrists belong to a number of different professional organizations—there are about a half-dozen of them—often opposing each other on various theoretical and practical issues, they present a group with a definite ideological uniformity and also with considerable similarity in their practice patterns. The practitioners of this group consist of psychoanalysts of various schools, and of those who have had partial training and

[1] Read at the 113th annual meeting of The American Psychiatric Association, Chicago, Ill. May 13-17, 1957.

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experience in analytic theory and practice; the latter being considered, and amazingly enough considering themselves, second class citizens within this particular camp. There are also wide differences in participation and devotion to research and teaching.

The D & O group is even more heterogeneous, ranging from practitioners who employ directive methods of psychotherapy such as reassurance, persuasion, suggestion, and support reinforced by advice and occasional tranquilizing or excitatory drugs, to those who rely primarily on various forms of organic treatment such as drugs, shock therapy, and psychosurgery. These practitioners have a definite organic orientation, carrying out physical and neurological examinations and medical procedures, such as blood tests, lumbar punctures, etc. Many of their explanations—to themselves and to their patients—and much of their research is couched in terms of organic medical knowledge. Actually, much organic research is not carried out by D & O practitioners, but by basic scientists. To a certain degree, this is also true for basic research in the analytic psychological field. The directive methods of psychotherapy of the D & O group are based more on so-called common sense, clinical experience, and the assumption of an authoritarian professional role than on the uncommon sense of scientific psychological theory. To a certain extent, they are guided by biological theory, although most of their therapies are crude, empirical methods such as shock treatment and lobotomy. The success of their maneuvers—and they can be quite successful—often depends more on the personality of the therapist than on the technique. This group is socially closer to the core of the medical profession in their allegiances and associations, in their professional interests and also in their training, which naturally favors the biological sciences and looks to them for guidance and progress. Davidson(1), in his interesting discussion of economics of psychiatric practice, pointed to the fact that certain psychiatric groups will make house calls, give "courtesy" discounts to colleagues, and see emergencies, which many A & P practitioners will not do. There are also a number of other social characteristics of these two groups, which Hollingshead and I have listed in our forthcoming book(2). I do not claim to be entirely objective in my appraisal of the two groups, although I am trying to take a neutral position. My sympathies are with the A & P group in spite of my appreciation of the need for treatment and particularly for research in the organic field.

It is my impression that the existence of a strong A & P group is one of the outstanding characteristics of American psychiatry. There are also other characteristics, as Lidz and Lidz(5), Ruesch and Bateson(8), Whitehorn(9), Knoepfel and Redlich(3), and others have reported. The relative importance of dynamic psychiatry, however, is striking and I will devote the rest of this paper to a discussion of this particular feature of American psychiatry in relation to the culture of our country. Let me make reservations before I continue: the first reservation is that in speaking of United States culture in this particular context, I am speaking of middle and upper class culture in large metropolitan areas, particularly on the Eastern Seaboard, the West Coast and the Midwest. The second reservation is a limitation of my discussion to dynamic psychiatry and the influence of psychoanalysis on this type of psychiatry. I will not discuss the much broader topic of why psychoanalysis has flourished in this country and influenced many areas of its cultural life. The question arises now why psychoanalysis has made such an impact on American psychiatry that it has led, in comparison with other countries, to the evolution and striking growth of a special type of psychiatry, first spoken of as psychoanalytic and later as dynamic psychiatry. To answer that this happened because a large number of Continental psychoanalysts, fleeing from dictatorship, found refuge on the shores of this country would be begging the question. Certainly, able and well-informed refugees in other fields of art and science have contributed to the culture of the host country, but they have not gained such widespread scientific and social importance. To answer that American scientists, practitioners, and the American public in general have accepted analysis because of their superior grasp of the pertinent questions would hardly do jus-

tice to the intelligence and integrity of the expert and intelligentsia outside of the United States. Actually, this type of argumentation—only in reverse—has been presented by some European critics: that Americans are gullible and uncritical and accept psychoanalysis without any good evidence. I believe that the answer is more likely to be found in certain peculiarities of American culture, and particularly the culture of its upper classes, which may explain the affinity of United States cultural values to psychodynamic thought. Underlying my thesis is the assumption that no culture can resist for a long time the impact of unassailable scientific evidence; however, if scientific data are of a low order of certainty cultural conditions will help or deter the acceptance of scientific systems and practices which are based on them. About the relative acceptance of dynamic psychiatry in this country, I will, in the absence of empirical research on this subject, proceed to speculate.

The first hunch I offer is that the American culture values rationality and, therefore, strongly believes in science. It accepts a "Science of Man" which endeavors more than anything else to replace the irrational with the rational. In general, Americans try to "face things squarely" and claim to believe in reason. To be "adjusted," as Ruesch and Bateson have pointed out, is very important in this culture. The second reason for the acceptance of dynamic psychiatry is its emphasis on development and growth. Anglo-Saxon culture, and American culture in particular, is a child-loving culture with a pronounced appreciation and esteem of children, in contrast to Latin and Germanic countries where the prevalent attitude is more authoritarian and favors the appreciation of the finished product, the grown-up. A science which optimistically emphasizes the importance of growth and the potential for development is likely to flower in a young pioneering culture of "self-made men." In connection with this, we might mention that a psychiatric approach which emphasizes the importance of heredity, of race, of biological characteristics, is less likely to develop in this country. The third reason is the emphasis on the individual's rights and privileges. Psychoanalytic psychiatry is basically a system of thought oriented about the individual. It recognizes that each patient is different from others and considers the rights of the individual patient more than the prerogatives of any collective group to which the patient belongs. It is the individual who is not rugged and also the individual who cannot or does not wish to be identified readily with powerful and established groups who often seeks and needs the help of dynamic psychiatry more than others. It is the individual who is caught up in the cross-currents of United States melting pot with its strong social mobility and rapid changes. In this type of social setting, dissatisfaction with one's self-realization, and self-conception of being neurotic are bound to occur more frequently than in stable and unchanging societies. In such a culture need for the type of intervention we have labeled "dynamic psychotherapy" and "psychoanalysis" is bound to be expressed. The dynamic psychiatrist (and actually most psychiatrists) is put into the role of a sage and friend who is supposed to provide guidance based on science rather than belief. One might also say that this culture is avid for sages and friends, probably because they are rare. There is also an implicit obligation in dynamic psychiatry to undo any wrongs which were inflicted upon the patient—as an infant, as a child—when he was helpless and could not defend himself nor determine his own fate. This sense of social justice, inherent in Judeo-Christian tradition and well embodied in the American culture, is one of the noblest and most appealing values underlying psychodynamic theory and practice. There are no words which can convey better the metaphysical basis of psychodynamic theory and practice than the words of the Declaration of Independence: ". . . that all men are created equal; that they are endowed by their Creator with certain inalienable rights; that among these are life, liberty, and the pursuit of happiness." The fourth reason is the avowed purpose of psychodynamic psychiatry to recognize and eliminate irrational fear. A strong intolerance for pain and fear are quite characteristic of American living; Americans are also quite prone to admit and to express pain and fear. During times of war, a comparison of soldiers of various

nations bore this out quite clearly. Present day American culture, in spite of the Puritanic heritage and possibly as a reaction to it, is by no means a Spartan one and powerful institutions in our society serve the purpose of eliminating pain, fear, and loneliness, and endeavor to make life comfortable and soft. To a certain extent, dynamic psychiatry may serve such a hedonistic trend. The last reason is mentioned by Lasswell (4), who thinks that psychoanalytic thought has been so avidly accepted in the United States because it has offered some guidance in what Sorokin called the sexual revolution of this country. Guilt over sexual activity in a country with strong puritanic tradition has been intense, and dynamic psychiatry offers some hope—based on scientific discovery rather than belief—to reconcile desire and conscience and to alleviate guilt, anxiety, and frustration. This particular function of dynamic psychiatry and its mother discipline, psychoanalysis, has often been misunderstood. Psychoanalysis and dynamic psychiatry have been accused by some adversaries of advocating license and indulgence. Nothing in psychoanalytic and psychodynamic teaching can be construed to permit such interpretation; Freud was an austere man who abhorred lack of discipline. Although he pointed very clearly to the primitive sexual and aggressive instincts which have such a profound influence on human behavior and make men seem to be worse than was commonly assumed, he also realized that man is much better than he seems to be. In connection with the importance of modern dynamic psychiatry for a proper orientation in sexual matters, we might add that both the "sex problem" in the United States and the preoccupation of American psychoanalysis and dynamic psychiatry with sex, have changed greatly. Today, the important theoretical and practical interests of psychoanalysis and dynamic psychiatry are the genesis and function of the ego, the problem of anxiety, conflicts with aggressive and dependency needs, and the defense mechanisms, and not only what has been referred to as the older "Id psychology," largely preoccupied with the vicissitudes of the sex drive. We might add, however, to our observations that psychoanalysis and dynamic psychiatry are less likely to flourish in a culture which has less guilt over sex, aggression, and dependency—either because behavior is freer and not under very severe controls, or because there has been a chance for better sublimation for individuals and groups.

In addition to the above considerations, we feel that psychoanalysis needs a tolerant and permissive culture for its development. It will not grow in a totalitarian or dogmatic culture. It never existed for any length of time under dictatorships, in societies with rigid caste systems and strictly defined social obligations, and it does not do well in subcultures with strong and stern doctrines. Recently, the Catholic and Protestant Fundamentalist opposition to psychoanalysis and dynamic psychiatry have become less formidable, but there is still inherent antagonism. Although psychodynamic psychiatry professes specifically *NOT* to have an explicit value system, it threatens the strict religious and political dogmas of other systems. It seems to do this by its implicit values rather than by explicit statement. Like other great intellectual movements, its spirit is revolutionary, even if most of its disciples—today—are conservative citizens. Sigmund Freud—whom Ernest Jones calls a revolutionary genius—furnished considerable intellectual ammunition to destroy our most carefully guarded shibboleths; however, Freud did not go beyond a statement of fact; being a true analyst, he was very cautious in his recommendations.

There is one additional feature of an economic nature which deserves mention. Treatment by methods of dynamic psychiatry is expensive for the individual patient and it takes a wealthy country to support this type of practice. To my knowledge, the United States is the only country where many dynamic psychotherapists earn a comfortable living and enjoy a rather high degree of social prestige. It is undoubtedly the country whose citizens are most willing and able to spend public and private money on behavioral therapies. I believe I should mention—after pointing to the reasons for cultural acceptance of psychodynamic psychiatry—two features of dynamic psychiatry and psychoanalysis which run counter to our cul-

ture. One trait—which has bothered me considerably—is a tendency to be dogmatic in writing and practice, and to accept too easily the doctrinnaire teachings; there is reason to believe that this trait will be overcome. The second point was referred to at the beginning of this paper: unfortunately, acceptance of a basic science does not mean implementation of a practice. Affinity of psychoanalytic ideas to cultural values of this country did not ensue in the wide-spread practice of analysis. Psychoanalytic therapy, largely for socio-economic reasons, is restricted to a very small segment of the population. Will this ever change without training a less expensive therapist or supplying public funds for such treatment or possibly discovering more economical methods of treatment?

To paint a picture of psychoanalytic and psychodynamic psychiatry thriving without challenge or criticism in the United States culture would be wrong. As elsewhere in the world, there is considerable opposition and resistance to psychodynamic theory: some of it critical and constructive, much of it more vociferous than informed. Dynamic and psychoanalytic psychiatrists have often been over-sensitive and unnecessarily defensive to such criticism and have stayed apart from the centers of learning and thinking where free discussion—*sine ira cum studio*—may take place. When the memory of past hurts becomes dim, the group may have less need to huddle together to protect the tiny flame of progress. Will psychoanalysis have an increasing effect on theory and application of education and the social sciences, and psychiatry turn once more to the biological sciences and therapy? Or, will in due time, as we hope, the various psychiatric schools and factions mature and disappear to make place for one scientific psychiatry? Is this expression of hope just a pipe-dream? Maybe—but I think there is some beginning evidence this wish will come true.

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SOME GUIDING CONCEPTS IN DYNAMIC PSYCHOTHERAPY [1]

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The characteristic of dynamic psychotherapy, as presented in this discussion, is that psychotherapy must be guided by current and past psychopathologic findings, with the technical procedures adjustable to the psychopathologic changes. In current thinking, psychopathology includes the two inseparably linked aspects of the overt and the covert. The overt data are directly observable and describable, including symptoms and dynamic factors. The covert data include dynamic factors which are not directly recognizable or even demonstrable. Most of us would apply to them the concept of the unconscious which, however, other psychiatrists and psychologists might reject. This theoretical difference should not have an influence on the therapeutic procedures. The adjective "dynamic" emphasizes the dynamic aspect which is inherent in psychopathology and the dynamic aspect of the therapeutic procedure. All factors which have dynamic significance in psychopathologic reactions or in the well-functioning of a person demand attention in treatment whether they be physiologic, psychologic, social, or cultural. However, their therapeutic significance depends on the constellation with other factors, the period in the person's life during which they occur, and the degree of their flexibility. These introductory statements will be recognized in the discussion of some concepts which are applied in psychotherapy.

Among the basic concepts of psychopathology might be mentioned the ready changeability of psychopathologic manifestations and their subjective coloring. The meaning of symptoms and dynamic factors varies according to the individual and within his life. Every person has his orientation in a given time and place and situation, and this needs to be investigated and its meaning established. The need for critical evaluation and reevaluation of findings is well recognized in the treatment of children and adolescents and of psychopathologically severely disturbed patients. It is not sufficiently recognized in the intensive treatment of psychoneurotic and minor personality problems, and this error may lead to psychopathologic complications or a therapeutic stalemate which could have been avoided.

Insufficient awareness of social implications and the exclusion of relatives from contact with the therapist may lead to hardships which could be avoided without impeding, or perhaps even favoring, the therapeutic progress. While going over my notes on a psychoneurotic patient who was treated ambulatorily over a period longer than a year, with very good therapeutic results sustained for many years, I found that I had completely and deliberately avoided contact with the marital partner. As is evident from the patient's material, a devoted wife suffered considerably from bewilderment and anxieties because of the changes in the patient's behavior during this long period of treatment. Had there been periodic interviews with the wife, I should have been able to alleviate her unnecessary anxieties without interference of the patient's treatment. This type of mistake is usually avoided in the treatment of behavioristically disturbed patients, especially when psychotherapy is carried out in a hospital which is psychotherapeutically well oriented, but may occur readily in a busy ambulatory practice.

Psychotherapy cannot be restricted to investigation and change of psychodynamic factors but should concern itself with all types of dynamic factors, including physical, family, and socio-economic aspects. The desire to carry out a procedure limited essentially to the psychodynamic aspects of the illness may appeal to one's scientific needs and to theoretical demands, but it will rarely be the best psychotherapy.

Dynamic psychotherapy must accept our limitation of etiologic knowledge and the changing of theories with the progress of

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psychiatry, including psychopathology, and of medicine in a constantly changing culture. In the history of medicine there has always been changing dominance of causal or teleological theories influencing medical treatment. We also can see a changing emphasis on the treatment of illnesses and their phases or of the patient as a person, of stress on influencing primarily the person or his environment, and on the psychologic or physical means of therapy. The therapist cannot escape the influence of the period in which he lives and its effect on his experience and growth as an individual. However, he must be aware of the influences and bring them into critical accord with the therapy he plans to practice. Such an attitude will prevent him from having goals which are too limited or too far-reaching and from focusing almost exclusively on conscious factors and material or on the exploration of unconscious dynamics.

It has become increasingly accepted that insight into the dynamics of a psychiatric disorder and an understanding of desirable adjustments are highly desirable goals for the therapist to obtain for guidance in therapy. The same need does not apply to the patient. A limited insight is always therapeutically desirable but frequently not possible. Fortunately the therapeutic results rarely depend on the insight obtained. This fact is not surprising when we consider the many and varyingly significant psychologic and psychopathologic actions which contribute to healing. The therapeutic stress on insight is linked to the high value which in our culture is placed on intellectual functions and to insufficient evaluation of emotional, biological, and social factors—a bias in favor of intelligence which many protagonists of the importance of insight would deny indignantly.

The study of the individual and of his development in the world in which he lives is of basic importance to dynamic psychotherapy. The significance of dynamic events in childhood can still be recognized in psychopathologic manifestations in later life. The social relations in the present are linked closely to those in childhood. The desirability of investigating such dynamic factors in the years over 50 has often been demonstrated. However, how far one should push and how the material elicited is to be evaluated depend on many factors. In the adolescent group, for example, anxiety-connected material may bring forth intense anxiety which in turn may lead to marked difficulty in concentration and occasional vagueness of concept formation, or hostile resentment with projections, which become a severe impediment therapeutically or may cause the psychiatrist to make an erroneous diagnosis of schizophrenic illness and change the treatment drastically. A change to a therapeutic approach which considers the alleviation of anxiety essential and a utilization of resources which are available despite the thinking disorder usually leads to a fast improvement of these disturbing symptoms. Afterwards, further dynamic investigation becomes possible if one is on the lookout for early danger signals and is able to evaluate the intensity of related anxiety. On the other hand, in elderly persons with unrecognized early cerebral arteriosclerosis, anxiety may lead to an organic type of thinking disorder which may be persistent. In such cases, a change of approach and goals is necessary.

An important point is that emotions have a different impact not only in intensity but also in regard to the phase of personality development in which they occur. Their meaning varies and their psychopathologic influence and expression differ. These facts must be considered in treatment, and the types of emotions and their meaning should be analyzed. Further knowledge will affect our theoretical formulation of the relationship of emotions to personality development.

Applying this general discussion to psychotherapeutic technique, I wish to mention first the desirability of considering which analytic procedure would best fit the psychopathologic problems present, including the patient's personality in his life setting. To be considered are duration and frequency of the therapeutic sessions, more active or passive participation of the therapist, and need for interpretations, guidance, and advice. The choice of terminology may reveal the therapist's conscious or unconscious attitude to the patient. Therapeutic interview, for example, has a different meaning than review or conversation. Elicitation of dynamics is

not the same as exploration. Any one of these techniques is desirable in specific situations, none of them in all.

The relationship between the therapist and patient has received much attention, and transference relationship and transference neurosis are recognized as valuable procedures. Less is known about indications, contraindications, and need for changes in procedures during treatment. In any therapeutic relationship the physician with his prestige, his unavoidable assertions on procedures and their meanings, and his personal life, exerts a strong influence on the patient. These factors are unavoidable and may be minimized or utilized by the patient's psychopathologically determined needs or the physician's conscious or unconscious motivations. In some conditions, resistances should be analyzed when they occur; in others, they should be dealt with indirectly, *e.g.*, in schizophrenic negativism or paranoid defensive reactions, expressed in aversion to the physician or to therapeutic influences. Provoking resistance should be evaluated critically.

The meaning of the closeness of two persons, where there is complete or partial exclusion of outsiders and where desirable and undesirable dynamic factors are enhanced, is little understood or therapeutically utilized. One speaks readily of the anxiety which this closeness may cause in some reserved, aloof, or schizophrenic patients. This explanation is insufficient and therapeutically undesirable because of the complexity of the situation which must be investigated. Based on careful consideration, the therapist should evaluate the desirability of an exclusive relationship with the patient or of inclusion of other pertinent people. The current tendency of psychiatrists to avoid active participation by consultants and their repeated direct contact with the patient under treatment deserves critical scrutiny. Experience in teaching hospitals emphasizes that the value or the detrimental effect of the actively participating consultant depends more on the technical procedure and on the psychopathologic condition than on anything else. My own attitude is that the consultant can be a constructive factor in treatment without interfering with the effectiveness of the therapist if he is willing to avoid assuming an active role.

The psychoanalytic concept of working through is important if applied judiciously and with a willingness to curtail or prevent working through when psychopathologic changes or general therapeutic consideration make this change desirable or necessary. Emotions and life experience may be kept stirred up while actual working through is impossible. Much repetition may prove to be undesirable, and decentralization and desensitization should be chosen as more effective tools. By decentralization is meant a procedure which makes the patient aware of the fact that he has treated a certain experience or a human relationship or a limited set of dynamic factors as the nucleus of his difficulties and that they have to be re-studied and re-attacked until solved. It is worthwhile to remember that such over-valuing is well known in many psychopathologic conditions, especially in paranoiac reactions. It is therefore to be expected that the working through would fail as a therapeutic tool in paranoiac and paranoid reactions, and in the related psychopathologic reactions which may occur in intense resentment, anxiety, and insecurity.

The possibility of undesirable, repetitious working through is illustrated by the case of a 42-year old married woman who suffered from a transient paranoiac episode. In the convalescent psychotherapeutic phase, her frequent abandonment in childhood by her parents was constructively analyzed. Two months later, her parents who had come to her aid during her illness left her home on short notice. The patient felt "painfully depressed." An analysis of the meaning of "painfully depressed" revealed the present intense emotional experience in its complexity and the corresponding childhood reactions without bringing out essentially new aspects. The therapy was therefore directed toward attaining the ability to accept her parents as they were then and had been, and to rely on a husband who although unsatisfactory in many ways was able to offer a special type of reliable strength.

There are emotional reactions which, in some psychopathologic settings, may be prolonged or intensified by attempts at working through. Outstanding among them may be resentment and sexual unrest. The physician's clinical judgment will enable him to decide at various phases of treatment whether to continue to have the patient work through these reactions or whether to urge

him to tolerate and disregard them and turn his attention in other directions of analysis.

The goals of psychotherapy as they are presented in the literature of the last few years seem to me to be largely acceptable except that I would more definitely stress the need for clear guidance by the individual psychopathologic conditions and the usable assets. It is important to estimate realistically what assets are therapeutically usable, or not available, or even detrimental. With regard to psychopathologic factors, there is now a willingness to accept the possibility of their persistence being more desirable than their removal. On the other hand, there has been a disturbing readiness to accept such a limitation without careful and prolonged study of other possibilities. This tendency can be seen in purely speculative statements that the removal of certain physiologic pathology (*e.g.*, migraine or skin disease) would lead to depressions which could not be helped or to disorganizing illnesses. In many patients, the essential goal of therapy is tolerance to what cannot be changed within himself or in the environment. Tolerance to one's limitations may, for example, be important when striving for life goals leads to emotional difficulties because of an unchangeable discrepancy between inadequacies and desired goals. The utilization of the time factor in tolerance and desensitization can be important. In other patients, the goal can be reached only if one's therapeutic activity becomes directed at achieving a synthesis as an outcome of analysis where a spontaneous synthesis does not occur. The therapist must then utilize the positive factors as they are found and are able to be utilized. He may assist in creating opportunities. In others, the goal is to help the patient to obtain purpose and meaning in life and to improve his relationship to his environment, strengthening his standards, and clarifying his goals. The development of self-control may be the most desired outcome of treatment in many types of psychopathologic disorders.

A therapist needs vision of what should and can be reached. During the course of treatment his imagination and experience will permit him to link analysis of motivation to the possible outcome whenever this active type of therapy becomes indicated. He will try to recognize foreseeable life situations and pathologic reactions which might be detrimental and he will also induce the patient to apply his abilities to his daily life.

Psychotherapy must concern itself with the patient's mode of living while under treatment, and later. The so-called routine which a physician outlines is especially important in long-term therapy outside of a hospital. The balance of work and suitable recreation, with acceptable attention to one's physical needs (sleep, food, alcoholic beverages, sexual activities, smoking, drugs) is the essence of everyone's mode of living. The presence of psychopathologic symptoms, such as intense emotions with thinking difficulties, may make temporary or long-term modifications in the patient's mode of living imperative. In some patients, interference or persistent active attempts at re-education of thinking and actions become important. Re-education with regard to faulty actions and tendencies is a dynamic process based on understanding of the various dynamic factors. It may take place through analysis without being actively introduced by the therapist. In other patients it can be achieved only by being made a recognized part of psychotherapy. This type of therapeutic activity may be indicated when one deals with an unwillingness to use self-control or with emotional abreactions, but not with true neurotic acting out.

In a 24-year old man, immature and rebellious behavior in college and in later life was related to his attitude toward authority figures whom he both respected and rejected. Further analysis revealed his lack of strong identifications in his life development. The important therapeutic aspects became the development of a reorientation to persons in his adult life, the understanding and correction of a faulty need to control others, the awareness of the rights of others, and his responsibility to others.

The treatment of another ambulatory patient who manipulated the people in his environment illustrates dynamic analysis and application to re-educational and rehabilitation aspects. In the course of treatment the patient stated that he felt "manipulated" by friends—for example, he felt at times that there was not an emotional relationship but that he was treated like an object. He was being used to further some ends. Analysis revealed that his parents, by putting great emphasis on scholastic prestige, had shown a disregard of his feelings and opinions. This attitude had been present in early childhood and,

he assumed, probably since birth because he was the first-born son of an orthodox Jewish family. Resentment of such attitudes was intense and could be traced back to childhood. In addition to this family constellation, another factor in manipulation was being used to bring about changes in the environment, leading to insecurity and a defensive attitude to others. He began to recognize his own resentment involved in feeling manipulated and his projection of his reactions onto the friend. When these dynamics became clear to him, they were analyzed further in this special connection, and he was advised to apply in a constructive way what had become known to him and to some extent adjusted within him. For reasons which need not be discussed in this context, I felt it unwise to develop a prolonged dynamic analysis, in which he had participated with an able psychiatrist before he had consulted me. The emphasis was put on application of changes in attitude and behavior, resulting in improved social and work relations. While brief repeated reviews of interpersonal relationships were utilized whenever the occasion arose, dynamic analysis proceeded simultaneously along other lines.

A therapist should remember the value of reassurance which is offered to a patient through the recognition of slight improvement in a long-term treatment. One should not insist that a depressed or discouraged patient struggle through an analysis of his life experiences without such help. There is no proof that medical harshness is an essential therapeutic tool or that a physician's aloofness and impersonality must always hide his sympathy.

Emotional reactions of marked intensity and prolonged duration may have a far-reaching pathologic effect. The effect of prolonged intense tension for which no outlet can be found resulting in a paranoid panic is well known. Less understood are transient paranoid projections or depressive moods with suicidal dangers as phenomena of prolonged intense resentment. An interesting example of the combination of intense anxiety with sexual insecurity is seen in the resulting sexual excitements in which the anxiety may be present in relatively pure form or be converted into fear or manic-like elation. In this type of disorganization, hetero- and homosexual drives are displayed frankly or in concealed form, often accompanied by angry outbursts and attack on others, or suspiciousness and projections. These reactions, *i.e.*, panic, resentment, or sexual excitement, may occur in psychoneurotic as well as in schizophrenic and depressive illnesses. Their occurrence demands a change in psychotherapy and often a change in the final goal to be obtained. In my experience it has never been necessary to abstain from dynamic investigations if one proceeds with a clear awareness of the significance of the psychopathologic changes and if, in marked excitements, one resorts to chlorpromazine as a means of emotional control which permits continuation of psychotherapy.

Psychopathologic crises in the psychotherapeutic progress demand decisions. It may be possible to alleviate the crises psychotherapeutically in ambulatory treatment or it may be necessary to continue in the protected atmosphere of a hospital, with an adjustable routine to occupy and distract the patient, and, if necessary, with the aid of modern drugs. An important point to remember is that unconscious dynamics become obvious in such crises. A knowledge of them offers valuable psychotherapeutic guidance.

In conclusion, I wish to repeat that dynamic psychotherapy is based on an awareness and understanding of the psychopathologic changes which take place at any time during the course of treatment. Changes in the overt or in the not directly observable dynamic constellation may demand a change in procedure or in formulation of near or distant goals. It is fortunate that psychotherapeutic knowledge progresses constantly, guided by newly acquired facts and by the adjustment of past theories to present knowledge. Psychotherapists of any period must recognize current limitations and expect future changes in theories, and improvement in procedures.

TREATMENT OF HOMOSEXUALITY BY INDIVIDUAL AND GROUP PSYCHOTHERAPY[1]

SAMUEL B. HADDEN, M. D.[2]

Few psychotherapists are enthusiastic about the results obtained in the treatment of homosexuality. The 1955 report of the Group for the Advancement of Psychiatry(1) stated:

> The homosexual who has no apparent anxiety and who admits no concern about his problem will be thoroughly resistant to treatment, and the threat of punitive measures will not render him amenable to treatment. With the use of a psychotherapeutic approach some homosexuals can benefit from treatment. This is particularly true of those individuals who demonstrate anxiety associated with their problem and are sincere in their desire for therapy.

We have all had many disappointments in the management of the homosexual, and my experience with their individual therapy has not been very rewarding.

Homosexuals seldom seek treatment except under duress, and we most often see them after they have been arrested and granted a suspended sentence on the promise of seeking psychiatric care. As a rule such individuals bitterly resent this condition and express the feeling that since nature has played a trick on them, no demands should be placed upon them to change their pattern of sexual behavior. I have observed that when a young homosexual associates with other homosexuals for a short time, the older and more experienced aberrants are prone to assure them that nothing can be done for their condition and that treatment is a waste of time. The acceptance of this opinion makes it necessary for homosexuals to rationalize their irregular sexual behavior, and to be emphatic in announcing that this way of life is most satisfying and that they would not change if they could. Because of acceptance by other homosexuals they are prone to feel that they have found a gratifying existence which they intend to follow. On only brief contact with them however, one readily appreciates what lonely individuals they actually are. Disturbed by their isolation from the main stream of society, and convinced that they cannot change, they become contemptuous of treatment efforts and sneer at a culture which expects them to alter their sexual pattern. When anxiety is experienced because of their sexual maladjustment they utilize it to build up the rationalization that homosexuality is what they want in life. Whenever this ego-protective rationalization fails, dangerous depression ensues; this is the principal reason for the high suicide rate among homosexuals.

From early experience with group psychotherapy I learned that the average homosexual had known such vigorous rejection by society that he was unable to present his problem before the therapeutic group. When he did, despite protective efforts of the therapist, the anxiety and hostility which he activated in the group usually were too disturbing and he generally dropped out of treatment. I have seen groups less upset by the revelation and discussion of incest than they were when homosexuality was disclosed by a member. Therefore I now keep homosexuals out of groups composed of patients with varied neurotic states.

The purpose of this presentation is to do little more than report a few impressions gained from the individual treatment of homosexuals over almost 30 years, from their treatment in groups with other neurotics, and from their progress in groups made up exclusively of homosexuals. Most of the experience has been in private practice. In selecting these patients I have included only males who have persistently and consistently in adult life preferred sexual experiences with those of the same sex, and who have had some degree of rejection or revulsion toward sexual union with females.

Over 3 years ago when 3 male homosexuals were forced into private treatment almost at the same time, an opportunity presented itself to initiate a group made up exclusively

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of active homosexuals. After several preliminary individual sessions the group was started. Two of the members were 22 years old; the third was 19. The 2 older ones had been active homosexually for a bit over 5 years; the youngest member had had an active homosexual career from the age of 12 when he began to frequent the neighborhood movie on Saturday afternoons.

This boy, Ben, a college student, came from a moderately wealthy Jewish family. At his home in another city he was a frequenter of all the homosexual haunts. Upon arrival in a university city, he plunged into the "gay" life of the community. Some months after his appearance on campus the members of a club to which his older brother had recently belonged began to press him to join. Fearing that his homosexuality would be discovered if he did this, he grew very anxious and began to cut classes. Informed of his impending dismissal, his parents paid Ben a surprise visit and demanded an explanation. When he eventually revealed the nature of his problem they sought psychiatric assistance for him. He was promptly placed in a sanitarium where he had 8 months of intensive analysis, without any benefit. On his discharge his family was advised that his condition was hopeless, since he did not wish to be helped. Because of the stigma of his homosexuality the parents wanted him away from home, and decided upon another attempt at treatment. Hence, he took up residence in Philadelphia.

When first seen Ben maintained that he had no desire to undergo change; he informed me that any psychotherapeutic efforts would be wasted because homosexuality was so attractive to him that nothing could influence him to give it up. He had set up an "establishment" in the appropriate zone of the city and entered into the "gay" life with zest.

Tom, one of the older boys, was equally emphatic about his intention to remain a homosexual. He admitted his condition to his mother and stepfather after friends had reported that he was associating with a "gay" group. His parents were already suspicious because he frequently remained away from home overnight and went on trips (which they knew he could not afford) with older men. At the time of coming into treatment he was "married" to a wealthy young physician and travelled with a group of homosexuals who were almost exclusively medical residents and students. He left our therapeutic group suddenly without any explanation after only 2 sessions. When met on the street about a year later Tom explained that the group with whom he associated had issued an ultimatum because they feared exposure if he continued in treatment. Because this homosexual circle was the only place where he had ever found significance, he said he could not tolerate giving up these friends.

Tom was an only child whose father had disappeared before the patient was 18 months old. The boy was reared in an apartment with his mother, grandmother and an aunt. He had no male companions, and when he started to school he could not integrate himself with boys and preferred to play with girls. His mother had many suitors, all of whom he felt were rough and loud-mouthed, and when he was about 11 she married the loudest-mouthed one of all. Tom was a brilliant student, graduating from high school at the age of 16, then immediately entering a novitiate for the priesthood. At the end of the first academic year he was dismissed without explanation. He maintained that during high school and the novitate he had no disturbing sexual feelings but realized he had effeminate traits and interests. On returning home from the seminary he spent much time with his aunt and her friends, and although he went out with many girls in the neighborhood he experienced no sexual feelings toward them. He took them to concerts, theatres and art museums, but had no male friends because he did not enjoy sports and the other activities in which they were interested. He was disturbed by his inability to integrate with his peers and felt very lonely. About six months after returning home he obtained employment in the office of an architect. Soon he made friends among artistic people, and became enthusiastic about them. He was invited to "gay" parties and while initially shocked by them he eventually met a physician with whom he fell in love. At first he was definitely disturbed by this unacceptable relationship and was constantly being admonished by his confessor to terminate the liaison. Eventually he stopped attending church, and during our brief therapeutic acquaintance he was most hostile to religion.

Bill, the third member of the group, was forced into treatment after he had revealed the nature of his problem to the family physician, who, without his consent, informed Bill's parents. Between the ages of 19 and 20 Bill had made 2 suicidal attempts and weeks before consulting me had disappeared from home and was ultimately located in an eastern psychiatric hospital as an amnesia victim (partial suicide). After his second suicidal attempt he had had psychiatric treatment for a short time, but did not reveal his homosexual problem until he was returned home after his amnesic episode. He was in a state of despair. Convinced by other homosexuals that there was no hope of change, and because of the disgrace he had brought on his family, he expressed a feeling that death was the only solution.

Bill was an only son, having 4 older sisters. His father was an exceptionally harsh man and frequently beat the patient with his fists until at 16 the son had developed into a very husky and robust young man, capable of defending himself. He always felt close to his mother and sisters. Despite the fact that he was an outstanding football player and all-around athlete in school, Bill was interested in aesthetic things; he became an expert hairdresser after practicing on his mother, sister and friends. Although he enjoyed considerable popularity because of his athletic prowess, he was never well integrated with boys, and around the age of 12 became aware of strong sexual feelings toward his

team-mates and other boys. During his last year in high school, following a row with his father, he left home and went to an all-night theatre, and in the washroom there he had his first homosexual experience. Despite intense feelings of guilt and remorse this initiated a very active period of homosexual promiscuity, although he constantly struggled against it. The idea of sexual relations with girls was repulsive to him. On graduation from high school he too entered a novitiate and was asked to leave at the end of a year. He maintained that while in the seminary he had no homosexual problem and was very happy, and was distressed by his dismissal. After leaving he became interested in the theatre and joined a local theatre group. His homosexual activities soon started again, and he left home to "live" with a man who was a university teacher. Although he loved this man the relationship was the source of little comfort to him, since the moral conflict led to severe episodes of depression. He felt possessed and doomed. His suicidal attempts were genuine, and I feel that his amnesia was a compromise suicide.

My first homosexual psychotherapy group began with these 3 youths. All were masculine in appearance although one dressed in rather "gay" fashion. At the first session I learned that all were casually acquainted and had often seen each other in homosexual haunts. The escapades of Ben were well known to Tom and Bill, and they soon began to speak of parties held at his "establishment." Their feelings about homosexuality were initially explored. Ben announced that he had no intention of changing and, in fact, had a great ambition to be "the most fabulous faggot in the land." He expressed the belief that this could be accomplished when he inherited some money at the age of 21. Tom said that he wouldn't change if he could because he was moving in a circle that would not be open to him if he were not a homosexual. Bill had no hope of altering, and, as already stated, felt doomed because of the intense urge he had for sexual experience with males. He had no similar feeling for females and although he enjoyed their company any thought of sexual relations with women nauseated him.

As consideration of their activities progressed, the front page story of the murder and dismemberment of a sailor by a homosexual known to all three of them was discussed. Bill and Tom had on more than one occasion been invited to spend a weekend with the murderer, as was the luckless sailor. Several other murders of or by homosexuals that had occurred in the area were then discussed. One of the group was well acquainted with a youth who had recently disposed of his parents by poisoning. The group sought an explanation of why homosexuals committed such violent crimes, and when it was suggested that only they could supply the answers after examination of their own feelings, anxiety mounted as they disclosed violent emotions activated by threats of exposure and blackmail. Before the first session ended they were in agreement that homosexuals were not as gentle and artistic as they appeared. At this and several subsequent group meetings not only were murders among homosexuals discussed but their frequent suicides as well. Eventually when the group was reduced to Ben and Bill, Ben's rationalization that he preferred homosexuality was completely destroyed; each, and Tom, freely admitted a desire to change and spoke of the many homosexual friends with whom they had discussed the problem who were just "covering up" their real wish to undergo liberation. Finally there was a rejection of the homosexual pattern which eventually became recognized as but a part of an inadequate behavior pattern which must undergo alteration. With their homosexuality presented to them as but one facet of their neurotic pattern of maladjustment, ego strength was gained which enabled them to pursue further treatment. At no time in this and subsequent groups was any attention focused upon the nature of their homosexual experiences or the frequency of indulgence.

The scope of this paper does not permit a description of the psychotherapeutic sessions, but the group's various fantasies in relationship to homosexuality were explored as were the unsatisfactory parental relationships, the disturbed nature of identifications with their own sex, and the factors which led to arrest of their psychosexual development.

After Tom left, the group was continued with Ben and Bill in attendance. They had already become strongly motivated to change. Bill was drinking to excess and soon recognized that all his homosexual experiences followed alcoholic bouts and that this drinking was, in effect, an advance excuse for yielding to the homosexual urge. Soon his drinking decreased and was finally discon-

tinued, and he became more efficient on his job. At work his isolation diminished and he began to join in the banter which was often sexually tinged. During the week he started visiting the homes of his married sisters and began to attend sports events with their husbands. When his family went to the shore for the summer he joined them on week-ends during which he associated with a group of young people. In the course of some roughhouse play on the beach his face was pushed into vigorous contact with the breast of a young woman, following which he experienced an erection and his initial erotic interest in the opposite sex. For several days after this incident he was almost completely preoccupied with fantasies of the full female figure; he dreamed of nothing else, and soon began ardent petting with a few older girls at his place of employment. His erotic dreams, previously homosexual, now became heterosexual; his sexual drive led to a period of promiscuous petting which was brought under control when he was admonished by his religious advisor. While I did not consider him ready to do so, Bill terminated treatment, after 10 months, feeling that he was fully a man although acknowledging that he still experienced homosexual feelings when he saw a well developed, robust male in a bathing suit.

Ben, the remaining member of the initial group, after several private sessions, was integrated with a group of mixed male psychoneurotics who were well advanced in treatment. On integration he did not reveal his homosexuality until another member of the group began discussing anxieties growing out of a series of early homosexual experiences. Ben then disclosed his homosexuality and found acceptance and understanding in this group. He did activate some group anxiety as a result of which there was considerable focus upon homosexual activity and feelings. All the members have re-explored the nature of their parental identifications and have benefitted substantially by Ben's presence and contributions. While he revealed recently that it has been about a year since he indulged in homosexual experiences, it is in other areas that progress has been most remarkable. Since his admission to this group another homosexual has been successfully added and has made gratifying progress.

A second exclusively male homosexual group of 7 members has enabled me to confirm the observation gained from the initial project. Members of this second group quickly destroyed the rationalization that they regarded homosexuality as a desirable way of life and all soon were able to acknowledge anxiety about their sexual pattern and admit a desire to change. Two young and extremely immature members were vigorously importuned by the others to cease conspicuous behavior when they were on the street together after leaving the group sessions. This occurred recently, and the assault has caused one to be voluntarily absent. The second, because of truancy and continued homosexual behavior, was returned to court custody but is again attending group sessions. The others have come to regard themselves as generally maladjusted rather than as pathetic persons upon whom nature has played a trick. They now recognize that their homosexual pattern grows out of earlier experiences, and realize that they can recover from the effects of these traumatizing experiences. Ben, from the first group, has attended 2 sessions of this group and has contributed substantially to its progress. The patients now recognize themselves as having been poorly integrated from early life and relate it to past experiences in their homes. After once admitting a desire to change they begin to show improvement in other spheres, quite often before there is any alteration in their homosexual behavior. General efficiency is increased and a greater sense of responsibility in many matters is developed. Parental relationships improve and character defects such as lying become less glaring. Some of the effeminate traits disappear, and while their artistic and aesthetic interests continue these are no longer mere entré to homosexual circles.

The homosexual, despite his protestations, is an unhappy individual who feels isolated from the main stream of society, and because of this sense of isolation he seeks the company of fellow homosexuals. Consequently, in treatment he gains a feeling of security when he is incorporated into a group made up exclusively of his own kind, designed to promote psychosexual growth. The therapist of such a group must be tolerant and acceptant; his very attitude toward the

group members is one of the most therapeutic factors involved in the experience. The only authority he should exercise is that which grows out of his knowledge of psychopathology and psychodynamics.

In the early phases of all groups there has been spontaneous discussion of the nature and frequency of members' homosexual experiences, but the therapist has never initiated such discussion nor shown any desire to be kept aware of the frequency and nature of indulgence as the group progresses. I have not been concerned about sexual acting out among group members and have never been censorial. This attitude is necessary to provide a beneficial experience to all.

The lack of prying on the part of the therapist has, I have felt, contributed to the development of ego strength, been appreciated as a manifestation of confidence, and has helped to ease the super-ego which still contains disturbing components developed by earlier authority. As members relinquish the comfort of their rationalization that they want to remain homosexual, they inevitably form a libidinal attachment to the therapist, and when this occurs it is necessary that he be patient about their continued attachments to homosexual friends and their frequenting of homosexual haunts. If an individual does not apear to be making a sincere effort, you can be sure the other group members will know of it and will provide the pressures that will eventually initiate a change. At such a time, the therapist may have to afford some type of protection to the involved member.

As the group becomes aware of their other patterns of maladjustment the therapist must offer some hope by indicating the frequency of the same patterns in heterosexuals with whom they must eventually identify. As one member phrased it, this gives them a feeling that they are "not as far left of center as we thought."

It is, as a rule, several months before any alterations are noted, and since I never inquire about sexual outlets, changes are first observed in other areas. For example, Ben, the one who aspired to be America's most fabulous faggot, was supported *in toto* by his family and planned an indefinite parasitic existence. Some months after commencing treatment he began to control his spending, then came a series of fantastic business plans. Next there was a job which he presented as being quite worthwhile but which was in reality unimportant. Then he had several actual positions which he described as better than they were, but eventually he obtained substantial employment which now supports him adequately.

Because of anxiety about the loneliness which may result from giving up their homosexual connections, most such individuals in treatment reach a critical point at which there is likelihood of regression. The homosexual drive may be remarkably diminished, or even absent, and patients may be adjusting to an heterosexual pattern but final "commitment" is difficult. This means giving up friends who have accepted them in their homosexuality. To "commit" themselves to heterosexuality involves the risk of identifying themselves with a group that would certainly reject them if their "past" became known. More than once I have felt that some of my patients have reached this stage in individual treatment and have discontinued because they could not make the final commitment. In the group the members are supported in this final phase, and with group encouragement and assistance they go on to complete their heterosexual development. When this phase is reached the patient does not fear the rejection of his old homosexual friends—his only fear is the certain stigmatization if his earlier problem is exposed when he enters heterosexual circles. It takes great courage to venture back into normal society after one has become separated through homosexuality. For those who have not moved too far out of heterosexual circles, this is less of a problem.

Summary

From my experience I have concluded that homosexuals can be treated more effectively by group psychotherapy when they are started in groups made up exclusively of homosexuals. In such groups the rationalization that homosexuality is a pattern of life they wish to follow is destroyed by their fellow homosexuals. This breaking down of their rationalization activates anxiety and a desire to change is created. Obvious ego-strength is gained by identification with

others who are also seeking socially acceptable goals. Identification with a group that has a healthy motivation soon banishes the feelings of isolation from which they suffer. When members reach the point where their homosexual drives have diminished or disappeared and they must completely reject all homosexual identifications and identify with heterosexuality they are aided in final commitment by fellow members. The group convinces its members that their homosexuality is not an affliction or trick of fate but a pattern of inadequate behaviour which can be changed.

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PSYCHOLOGICAL ASPECTS OF PREJUDICE WITH SPECIAL REFERENCE TO DESEGREGATION

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INTRODUCTION

The decisions of the Supreme Court concerning segregation in the public schools and buses have recently accelerated the pace of racial desegregation in the South. This has brought to the fore the subject of prejudice which forms an important aspect of the problems connected with desegregation. Apart from their obvious interest in such matters as private citizens, psychiatrists should especially concern themselves with the subject of prejudice for two additional reasons.

First, psychiatrists are being called upon increasingly to advise and consult with educational leaders and social agencies who must reckon with prejudice in their plans during the current period of transition in race relations. The Supreme Court itself established an important precedent for such consultation when it heard testimony from social scientists before making its decision on segregation in the public schools. Since that time lesser courts and administrative bodies have (on both sides of the issue) appealed to psychological facts and theories to support their decisions. To offer useful guidance and counsel in these matters psychiatrists themselves need to be clear about the nature of prejudice, its origins, and its enormous social effects.

Secondly, prejudice is a symptom of a mental disorder. Not a major disorder, to be sure, in terms of individual psychopathology, but certainly of major importance in its social effects. Although the issue of desegregation may have drawn attention to the importance of prejudice, we should remember that prejudice is really a mode of thought and not an attitude on any one question. The prejudiced person does not perceive accurately or think clearly. He does not perceive clearly because he attributes to the objects of his prejudice qualities which they do not in fact possess; and he does not think clearly because he generalizes unwarrantedly from the one to the many without discriminating individuals within a category. Such perceptual and thinking disorders do not come about easily, nor are they easily modified. Prejudice in fact often lies deeply rooted within the personality. These are some of the reasons why we think of it as part of the problem of mental health.

Although many aspects of the psychology of prejudice are still imperfectly understood, there exists a body of knowledge on this subject with which psychiatrists should familiarize themselves. In this article we present a review of this knowledge. Although we have used examples from problems of race relations we hope this will not submerge our main point that prejudice is a minor mental disorder which may become symptomatic in connection with any issue. We have drawn upon the rather extensive literature on the subject and also upon personal experience gained from interviewing many persons living in communities where prejudice was strong or had become activated by recent events, such as actual or impending desegregation of schools. We have participated in the preparation of a fuller report on the psychiatric aspects of desegregation which those specially interested in this subject may wish to consult for further details(1).

THE NATURE OF PREJUDICE

Definition.—The etymological origin of the word prejudice indicates a judgment prior to examination of the facts. However, in modern usage the term has come to mean not only prejudgment but also judgment uncorrected by new knowledge. The prejudiced person exposed to new facts may simply fail to perceive them and hence his attitude remains uninfluenced by them. Prejudice derives its importance then not so much from the quality of prematurity and hastiness of judgment as from that of rigidity(2). Prej-

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udicial attitudes are often sustained against the facts by values and sentiments strongly intrenched within the personality.

The Power of Prejudice.—From the foregoing we might infer that motives of great intensity support prejudicial attitudes, and this is indeed the case. The neglect of opposing facts which is required to maintain a prejudice can only be accomplished because strong emotional forces underlie the prejudicial attitude. These irrational forces are strong enough in many instances to over-ride considerations of immediate personal security. In the service of prejudicial attitudes, men frequently expose themselves to economic ruin, to physical violence, and to punishment for breaking the law. In understanding prejudice, psychiatrists and psychologists must first clearly understand that it derives from strong mental processes the sources of which can powerfully influence men and events.

FACTORS WHICH PROMOTE PREJUDICE

Of psychological factors which promote and sustain prejudicial attitudes, by far the most important are fear and what we shall call mental rigidity.

Fear.—Fear diminishes perceptive acuity leading to lack of discrimination between what really threatens and what is imagined to be threatening. The jittery sentry may shoot his colonel as an enemy intruder. A fearful person is likely to perceive all kinds of harmless objects and persons as threatening.

Fear also evokes adaptive measures which will reduce its accompanying tension. Among such measures are efforts to get rid of the source of the fear or tension. If the source is perceived within oneself the tension may be lessened by transferring the source outside oneself. Fears which concern the general area of self-esteem, status, and prestige are commonly handled by the device of blaming someone else for what goes wrong. These other persons are appointed "scapegoats." The prejudiced person elevates his poor self-esteem in an illusory fashion when he feels himself superior to *anyone and everyone* of a scapegoat group. He does not have to prove his superiority by superior performance. It is a given, resulting merely from belonging to one group and not another.

This pattern requires that these other persons be seen as threatening when in fact they are not. The perceptive distortion mentioned above permits this. Thus the fearful person often cannot perceive correctly and (perhaps unconsciously) does not want to perceive correctly. He feels at least somewhat better about himself if he misrepresents the environment as being more hostile than it really is. At the same time the increased conviction of danger from without reinforces the original fear. This further promotes the distorted perception. The prejudiced person thus can find himself in a vicious circle in which fear promotes a false perception of the object of prejudice which is reinforced by the need to project blame; the false perception in turn promotes more fear.

The influence of prejudice on perceptions has been studied experimentally, for example by Allport and Postman(3). They showed a group of white persons a drawing which depicted a white man and a Negro talking together. The white man held a razor. In later descriptive reports of this drawing more than half the white persons described the Negro of the picture as holding the razor.

Prejudiced persons tend to perseverate in their perceptions. For example, in another experiment(4) the subjects were shown a drawing of a cat and then successively a series of transitional drawings, which gradually assumed the likeness of a dog. Prejudiced persons reported that the drawings exposed were those of a cat far longer than persons who were unprejudiced. They clung to the original perception; they could not believe their own eyes.

Prejudiced people lack discrimination in their perceptions of other people. They fail to see the subtle shades of difference between people. They tend to believe that other persons are much more like themselves than they are, that is, they project their own attributes onto the people with whom they come in contact(5). They form stereotypes of other people and act in accordance with these stereotypes rather than responding to individual acts of individual persons.

Mental Rigidity.—Since not all fearful, guilty people are prejudiced, we must con-

sider another factor to account for prejudicial thinking. Prejudiced people seem to be characterized by an abnormal rigidity of thought. This might be inferred from the fact that prejudice implies a failure to learn from experience, but it has been confirmed by experimental studies.

The prejudiced person is resistant to new modes of thought. For example, persons who rate high in prejudice have greater than average difficulty in changing their manner of solving problems. If tested in a series of problems requiring different methods for their solution, they cannot change from one method to another so easily as persons who are rated low in prejudice(6).

Prejudiced persons are also intolerant of ambiguity and uncertainty. They have difficulty admitting ignorance(7). They tend to categorize people and objects rigidly and into sharply differentiated "good" and "bad" groups without consideration of intermediate states(8, 9).

Finally, we should note that prejudicial attitudes are rarely confined in one person to one topic or group. One careful study has shown that persons prejudiced towards one group, *e.g.*, Negroes, are likely to be prejudiced towards other groups, *e.g.*, Catholics or Jews(10).

Having described what prejudicial thinking is, we shall next discuss how it comes about and what factors modify or enhance it.

INFLUENCE OF LEARNING AND EDUCATION ON PREJUDICE

Men are not born prejudiced. They must learn to perceive and think in a prejudiced manner. For prejudice is a pathological extension of the human capacity to categorize and generalize the objects of the environment. A young child at first does not see the similar qualities shared by different objects. He usually learns to abstract these shared qualities in the middle years of childhood, say between four and ten. During this period he establishes important categories for things and people and begins to respond to them partly according to the categories to which he assigns them. Some automatic categorical responses are necessary and helpful in our adaptation to the environment. If we can make quick judgments about our surroundings we economize time and effort. We are led into difficulties, however, by two kinds of errors. First, the categories we erect may be incorrectly characterized. For example, the word "Negro" should ordinarily denote persons of a particular race usually having heavily pigmented skin and certain features of hair and face. In addition to these ethnic qualities, the category Negro has had encrusted onto it in the minds of many white persons a great many qualities which are not demonstrably more common among Negroes than among white persons. These additional attributes such as that the Negro is lazy, untrustworthy, easy-going, etc., amount altogether to a kind of myth about the Negro. Such a myth provides an extremely inadequate guide for behavior towards Negro persons. Secondly, responses may be made to the category rather than to the individual person who may belong to the group. A person may thus come to respond to a Negro because he is a Negro (whatever that may mean to this person) and not because of his qualities or behavior as an individual person. Because of the wide individual differences among persons of certain groups responses based only on categorical differences are bound to be clumsy and often quite inappropriate and harmful.

These two errors, inappropriate characterization of categories and response to categories rather than to persons are apparently acquired rather than inborn. At any rate, very young children do not show prejudicial attitudes, but older ones often do(10).

We think we may generally equate opposition to desegregation with prejudice. We realize that there are some rational (if selfish) reasons for opposing desegregation and that there are many factors, such as economic and political factors which contribute to the problem of desegregation in addition to the psychological obstacles. But most of the opposition to racial desegregation is based on prejudicial thinking about Negroes. It has been found that opposition to desegregation increases with increasing age(12, 13). One may accurately speak of an age gradient of prejudice at least with regard to desegregation. This suggests both that prejudicial attitudes are learned and that

once learned they are not readily unlearned, partly because the prejudiced person keeps himself from having experiences or gaining information which might correct his prejudice.

Still other evidence that prejudice is learned comes from studies of the evolution of prejudicial attitudes over broad sweeps of time. For example, Woodward has shown that prejudice against Negroes was very much less in the early and mid-19th century than it became in the late 19th and early 20th century. Indeed the enactment of the Jim Crow laws around the turn of the century was opposed by many horrified protests from responsible persons in the South (14). This kind of evidence thoroughly discredits the notion that certain prejudicial attitudes are innate, or are "part of human nature."

Although we have emphasized the rooting of prejudice in emotional forces, we do not mean that it is entirely uninfluenced by educational measures. As mentioned above, prejudiced persons frequently deprive themselves of correcting information. Yet such information does reach many prejudiced persons gradually and often involuntarily and does in time erode some prejudices. For example, again assuming a correlation between prejudice and opposition to desegration, such opposition is much less among persons of college education than among persons with only a grammar school education. Those with high school educations fall in between the other two groups(12). Also, significantly more persons now acknowledge the fact that Negroes are just as intelligent as whites than were able to accept this fact in 1942(12). This change presumably reflects the power of educational measures on gradually reducing prejudicial attitudes.

Although we know that prejudices are learned we know less about how they are learned or why some people learn them more readily and more extensively than others. However, two important factors emerge from studies which have been made of this question. First, prejudices are frequently acquired through imitation; they are copied by children from their elders, or by ignorant persons from their ostensible superiors. Such imitation at least partly accounts for greater prejudices towards Negroes in certain sections of the country, *e.g.*, the South, than in others(2, 12, 15). Much prejudice simply echoes uncritically the stereotypes of the local culture. Such prejudices are harmful in effect, but not necessarily hostile in motivation as are others which derive more from fear and guilt. Which brings us to the second of the environmental influences favorable to the development of prejudices.

Several studies, admittedly of small numbers of persons, have strongly suggested the influence of tyrannical attitudes towards children on the part of parents in the later development of prejudiced attitudes in the children(16, 17). Presumably the authoritarian attitudes of the parents inculcate fear in the children and this fear originates prejudices in the way we have previously described. For example, irrational punishments by the parents can blur a child's distinctions between sources of danger and sources of security. He may then begin to respond inappropriately to friends as if they were enemies. And, secondly, harsh treatment of the child by the parents makes it difficult for the child to acknowledge his own deficiencies or accept blame; to preserve some self-esteem he resorts to the projection of blame on others.

We cannot distinguish sharply prejudices learned by imitation from those learned as responses to maltreatment at the hands of others. No doubt mixtures of both origins blend in most prejudiced persons. Although one might suppose that prejudices which are merely imitated would be more plastic and more easily given up than those derived from maltreatment, this does not seem to be the case. Heated passions may come into play as readily for a prejudice which is chiefly "cultural" as for one which is more "personal." In fact, the identification of a prejudice with the will of a group frequently strengthens the fervor with which it is held by giving it a more authentic quality. Which leads us next to the influence of groups on prejudices.

INFLUENCE OF GROUP RELATIONS ON PREJUDICE

As mentioned earlier, prejudiced attitudes especially arise to combat thoughts of failure

and loss of status or prestige. Prejudiced persons are sensitive to the opinions of others about them. Accordingly prejudicial attitudes usually express important aspects of the prejudiced person's relations with the various groups of which he is a member.

Attitudes towards desegregation differ markedly in the various groups to which one person may belong. For example, the nation as a whole has adopted a program of desegregation and integration, but certain communities and States express implacable resistance to this goal. A resident of such a community can easily find himself in conflict between loyalties to his State and the Nation. Similarly, economic motives opposing desegregation may conflict with religious ideals which endorse it.

In conflicts of this order, the average person aligns himself with those to whom he feels himself most closely tied. These are nearly always persons with whom he has frequent personal contacts. It thus happens that the influence of a local leader known to local people may far exceed the persuasive authority of the Supreme Court or the President of the United States. These remain distant and shadowy figures, almost abstractions; the local leader may have shaken the hands of half the people in town.

Strong as they are, such personal influences rarely subdue entirely a person's awareness of the other side of the issue. The person prejudiced about desegregation remains aware that his opinion belongs to a minority of the nation and the world. And he would like to have the approval of everyone, not only of his own community. This leads to the efforts, observed in interviewing them, which such persons make to present themselves as rational, scientific, and personally unselfish in the matters at issue. As the English essayist Hazlitt put it, "prejudice is never easy unless it can pass itself off as reason." The prejudiced person disclaims any personal dislike for "niggers," or any wish to see them treated unfairly. He presents himself as guided only by sound "scientific" principles which have shown that "the negro is basically inferior," or "cannot learn," or "is not like other people." This resort to pseudoscientific arguments expresses an awareness in the prejudiced person of another side to the issue and a sensitivity to other groups besides his own immediate one. In this, as we shall mention in a later section, lies much hope for the resolution of prejudices.

Although the prejudiced person takes cues from his immediate group, his own habits of thought frequently isolate him from important knowledge about his own group. It may happen that an articulate minority can persuade the majority that "everyone believes as we do," when this is in fact not so. A study of private and public opinions on certain issues in a small Southern community demonstrated this neatly(18). The observer in this study succeeded in persuading the citizens of this town to express themselves first in groups and next privately to himself alone on a number of matters then pressing in the community. These included such issues as the relative merits of baptism by total immersion and baptism by sprinkling. In their public avowals, to continue the above example, 90% of those questioned favored sprinkling, but privately 71% said either form was equally acceptable. In this and other examples, the citizens responded not to the wishes of the group but to their own myth of what these wishes were. We can hardly over-estimate the importance of such studies for the understanding of prejudice and the means by which a vocal minority may sustain an illusion of its representativeness and its power long after the majority of people in a group have at least begun to think differently on the matter at issue. There are strong grounds for believing that in the South, for example, the number of white persons favoring integration of the races is very much greater than seems to be the case if relative strengths of opinion are judged solely by vocal power(12, 19, 20, 21). We must not confuse attitudes and wishes with articulateness.

Influences of Leaders on Prejudicial Attitudes.—Important implications for leadership arise from the foregoing. The business of leaders is to express and execute the will of a group. But often this will remains latent or silent because the majority of persons in the group are either ignorant of the true will of the group or fearful of expressing an apparently deviant opinion. With re-

gard to overt action they remain passive or neutral. False leaders may exploit the silence by claiming a fictitious mandate from the group. The group's real wishes can only become energized by other leaders who correctly interpret and carry out these wishes. But this requires that such leaders themselves distinguish mere social conformity in the expression of prejudices from strong prejudicial attitudes.

Relations Between Prejudicial Attitudes and Overt Behavior.—The sharp differences often observed between private and public opinions on important issues permit us to infer an equal gap between either private or public opinion and what a person will do when confronted with a changing situation. This is confirmed by a number of studies. A person's statements of his attitude on a given question provide no reliable index to his behavior when put to the test.

For example, LaPiere(22) travelled across the United States with a Chinese couple being received everywhere with great hospitality in hotels and restaurants. After the journey he wrote to the various hotels and restaurants where they had stopped asking if these establishments would receive Chinese as guests. Over 90% of the respondents (who had actually served the Chinese couple) said that they would not do so. Saenger and Gilbert(23) interviewed customers of a department store concerning their attitudes towards Negro sales clerks. They found that 21% of those who had just dealt with Negro salesclerks said that they were "opposed to the hiring of Negro sales personnel generally"; 20% of those customers who talked to Negro clerks stated one hour later that they had never seen any Negro clerks in that store. Some who insisted that they would never make a purchase from a Negro clerk had in fact done so an hour before the interview. Similar inconsistencies between verbal statements and actual behavior have been found in connection with desegregation of the schools. For example, strong verbal opposition preceded desegration of the schools in Tucson, Arizona(24), and Washington, D. C.(25). But when desegregation occurred the transition encountered almost no opposition.

What these gaps between private and public opinions and between public opinions and overt behavior mean (among other things) is that we need to distinguish between prejudice and discrimination. Discrimination (*i.e.*, unfair treatment of certain groups based on prejudice) may occur in conformity with an idea (often erroneous) of local custom or law. It arises from a need to conform much more often or just as often as it arises from important prejudices. And it is correspondingly much more susceptible to change. Because when a person changes his notion of what is acceptable to the group (especially in the situation immediately confronting him) his behavior can rapidly fall into line. After his behavior has changed his prejudices may alter, partly because new experiences have weakened them and partly because a man needs to think that he acts in accord with his convictions. If he changes his behavior to conform to some new social pattern, he will fairly soon change at least the outward expression of his attitudes in order that his behavior may seem consistent with his beliefs. This leads us to the important relationship between prejudice, discrimination, and the law.

How Prejudices and Behavior Related to Prejudices Change.—One often hears that "you cannot legislate prejudice away," or, in the words of William Graham Sumner, "stateways cannot change folkways"(26). We do not think that anyone ever supposed that legislation or administrative acts could change prejudices directly. But what they can do is bring new experiences to a prejudiced person so that he may revise his misperceptions of the objects of his prejudice. Legislation can reduce discrimination and the lessening of discrimination reduces the separative isolation which contributes to prejudices(21, 27).

A number of studies have demonstrated the lessening of prejudice following the lessening of discrimination through administrative changes. For example, a study of attitudes towards Negroes among persons living in segregated and integrated housing projects showed that those living in the integrated housing projects had markedly less prejudice against Negroes than those living in segregated projects. Moreover, those who had moved from a separate to an integrated

project reported a much greater lessening of prejudice against Negroes than did those who had remained in segregated projects. Approximately 75% of the former group changed their attitudes, only 15% of the latter group(28).

Already since the Supreme Court's decision on desegregation of the schools more than 300,000 Negro children have entered schools previously exclusively white. This has brought to several times that number of white children their first close contact with Negro children. We suppose that these contacts are on the whole acting to reduce prejudice.

Clearly not all contacts between two groups reduce prejudice. Segregated buses provide a form of contact between the races, but one which promotes attitudes of superiority and inferiority in the two groups towards each other. More helpful, or if we may use the term, more therapeutic are experiences where equality is assumed. Of such are the new experiences provided by desegregated schools. Even more therapeutic, we believe, are experiences where common goals are shared and worked for together, and this, experiences in the Army have convincingly demonstrated. Prejudices among white soldiers toward Negroes fell markedly after white and Negro soldiers had fought together(29).

Gathering together these various influences and other factors, we suppose that changes in prejudice come about somewhat in the following manner. We shall illustrate with the process of desegregation. Certain social and economic changes first make disadvantageous prejudicial attitudes and discrimination towards a whole group. Such economic and social changes occurred throughout the twenties and thirties of this century and radically altered the position of Negroes in our society. These changes were accompanied by increasing experiences and educational measures which tended to correct misperceptions about Negroes. Together these forces created a climate of opinion which not merely favored but positively pressed for a change in their legal status as Negroes. This was given expression in the Supreme Court's decisions on desegregation in schools and buses in the mid-nineteen fifties. These decisions had two further effects. First, they greatly increased discussion of the issue thus providing increased opportunities for corrective information to seep through to prejudiced persons; and, secondly, they imposed immediate experiences of Negroes on a great many white people who had formerly isolated themselves or been isolated from Negroes. These discussions and personal experiences, still at this time confined to a small number of people, reduced prejudices (or at least their overt expression) still further. They thus prepared the way for still further judicial or administrative acts bringing further integration of the races. Thus some lessening of prejudice probably must precede judicial and administrative acts. But these in turn may precede widespread reduction of prejudice. Probably considerable prejudice towards Negroes will remain long after formal and legal integration has occurred across the country.

Summary and Conclusions

We began by describing prejudice as a minor psychological symptom, an expression of blurred perceptions and unclear thinking. We mentioned its principal origin in fear and its frequent support by a need to reduce guilt through projecting blame onto others. We emphasized the deep roots of prejudicial thinking within the personality.

In the later sections of this article we described a number of factors which can modify the expression of prejudice and its influence on behavior. We pointed out that statements of prejudice and, still more, overt behavior based on prejudice are strongly influenced by groups and by a person's judgment of what the group to which he principally belongs wishes. This section of our paper may make prejudice appear a great deal more plastic than our first sections supposed.

We think this apparent inconsistency can be harmonized by distinguishing prejudicial thinking and individual prejudices. Such faults of thinking as overgeneralization and responses to categories rather than to individuals cannot readily be given up, especially when they are sustained by fear and

have been practiced for many years. But individual errors of judgment can be corrected by new experiences. People can change their ways of looking at a particular problem, even though it takes much longer for them to change their general habits of approach to any problem.

These new ways of looking at a problem may come through new experiences brought about by legislative, judicial or administrative acts. Changes of behavior will follow awareness of new laws or customs; changes of attitudes may come later as the new experiences correct misperceptions and as the changing person seeks to bring his attitudes into line with his conforming behavior.

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TOWARD A DEFINITION OF THE THERAPEUTIC COMMUNITY [1, 2]

HARRY A. WILMER [3]

The term "therapeutic community," in its application to the mental hospital, is a relatively new term, and one that is not always clearly understood or precisely used. What do we mean when we speak of the therapeutic community in the mental hospital? Unfortunately, some of us may mean one thing and some of us another. The term has come to have a wide variety of meanings, many of which are vague, misleading, euphemistic, or even totally erroneous.

An effort must be made, I believe, to arrive at some reasonably precise even if tentative, definition of this term in its specific application to the mental hospital. Otherwise, a scientifically valid comparison of our observations on the efficacy of the therapeutic community in the management of mental illness will become increasingly impossible.

"A term," Bridgeman points out, "is defined when a condition is stated under which I may use the term and when I may infer from the use of the term by my neighbor that the same conditions prevail." As a first step toward a definition of the term "therapeutic community" for our purpose, therefore, I propose to describe the conditions under which a mental hospital may justifiably be called a therapeutic community as I see it.

What is the task such a hospital sets itself? How does it go about this task? What does it aim to accomplish? What are its results? The answers to these questions call for philosophical, naturalistic, and technical observations (6, 24, 25). In this paper an attempt is made towards a broad definition; and a description of a therapeutic community at the U. S. Naval Hospital, Oakland, California is presented.

[1] Read at the 113th annual meeting of The American Psychiatric Association, Chicago, Ill., May 13-17, 1957.

[2] The opinions contained herein are the private ones of the author and are not to be construed as the official views of the Navy Department or the views of the Naval service at large.

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THE THERAPEUTIC COMMUNITY CONCEPT

The concept upon which the therapeutic community rests is not new in the history of mental treatment. The colony at Gheel, Belgium, which has been in continuous existence since the 13th century, is one example where the patients are afforded a much more varied social opportunity than in a mental hospital, but we must keep a clear distinction between community care and a therapeutic community where the patients themselves interact under trained psychiatric guidance. While there was a certain amount of ideal patient participation in the planned therapeutic program in the American (23) as well as the British armed forces during the war, after demobilization the momentum appeared to diminish in the American scene but retained some of its force in Britain. An extensive methodical scientific exposition of it was made in 1952 by Maxwell Jones (11), who has operated a therapeutic community in psychiatric hospitals in England for the past 16 years, following upon the early war work at the Northfield Military Hospital (4, 5, 7, 9, 16).

The basic departure of the therapeutic community concept from traditionally established concepts of the mental hospital is the emphasis that it places upon socio-environmental factors in the patient's hospital experience. In the hospital which operates as a therapeutic community, socialization and the sense of belonging take their place along with psychotherapy. The traditional order of hierarchy is reversed, and the hospital is regarded as the patient's world rather than the doctor's domain; thus the traditional staff attitudes and staff-patient relationships are considerably altered. So also are the procedures employed: self-control, dignity, and trust supplant excessive imposed controls, restrictions, regimentation, and tradition-bound rituals.

The hospital is conceptualized literally as a form of community with its special culture and subcultures, similar both in the family sense and in the larger sense to the communities in the outside world from which the

patients have come and to which, it is hoped, they will again be able to return. Its operations are designed to create a social environment—a therapeutic milieu—which gives the patients and the staff a sense of membership in this community.

The therapeutic community may use any or all of the somatic or group or analytic or nonanalytic therapies; but its basic therapy is milieu therapy. It is neither authoritarian nor democratic in a political sense, nor permissive in a play-therapy sense. Its efforts are not dictated by "humanitarian" purposes, but by therapeutic purposes which are humane.

It imposes limits on certain forms of behavior, initiating these limits from the members whenever possible. It takes what it can use from behavioral science, psychology, sociology, and anthropology, and employs its borrowings for the practice of medicine. It strives to get away from the use of locks, mechanical restraints, punishment, and suppression of ideas and feelings in the belief that these practices do not serve therapeutic ends. Instead, it fosters, by every possible means, an environment without fear and distrust, in which patients and staff feel safe and in which communication is relatively free. It operates successfully only in an elastic atmosphere where learning, by both patients and staff, is the enduring task. It seeks continually to solve its problems in terms of interpersonal relations, by helping the patient to identify himself with a social group and through identification modify his social attitudes and behavior because of his growing awareness of his role in relationship to other people.

Its ultimate objective and the general means by which it attempts to attain this objective have been summed up by Main as follows:

> The socialization of neurotic drives, their modification by social demands within a real setting, the ego-strengthening, the increased capacity, sincere and easy social relationships, and the socialization of super-ego demands, provide the individual with a capacity and a technique for stable life in the real world(16).

And by Jones and Rapoport as follows:

> A therapeutic community differs from other hospitals in that it is committed to the idea that socio-environmental and interpersonal influences play an important, though not exclusive, part in the treatment program, and it is characterized by an atmosphere of intimate, spontaneous face-to-face interaction in which lines of communication are relatively free, with both patients and staff having access to the total body of relevant knowledge in the life of the institution(15).

This is only a beginning in the problem of the conceptualization and definition of the therapeutic community. The process of the therapeutic community and change will be reported in separate communications(33). In terms of what Bridgeman postulates I want to make some attempt to develop a frame of reference. This will be done in 2 ways: an objective inventory of data which allows for comparison between these social organizations, and a description of our community.

A BASIS FOR COMPARING THERAPEUTIC COMMUNITIES

Hospitals which practice the therapeutic community concept are not all alike in their fundamental structure and process and, as a result, do not follow an invariable pattern. In comparing different therapeutic communities with each other, therefore, the scientist must accurately identify the *type* to which he is referring in each instance. This means that he must be discriminatingly aware of the basic ways in which they are dissimilar, as well as the ways in which they are similar.

The following outline is proposed as a basis for making such an identification:

I. FACILITIES
- A. 1. One ward, 2. Part of a hospital, 3. All of a hospital.
- B. 1. Unlocked, Partially locked, 3. Locked.
- C. 1. Adequate general physical facilities, 2. Fair, 3. Poor.
- D. 1. In populated place, 2. Near populated place, 3. Isolated.
- E. 1. Special psychiatric hospital, 2. State hospital, 3. Part of a medical-surgical hospital.
- F. 1. Recreational/occupational facilities adequate, 2. Fair, 3. Poor.

II. PATIENT SAMPLE
- A. 1. Unselected, 2. Partially selected, 3. Totally selected.
- B. 1. Mixed sexes, 2. Occasionally mixed, 3. Unmixed.
- C. 1. Mixed race/creed, 2. Variable, 3. Selected.
- D. 1. Mixed social/economic, 2. Variable, 3. Selected.
- E. 1. 10 to 30 patients, 2. 31 to 100 patients, 3. Over 100.
- F. 1. Mixed diagnoses, 2. Variable, 3. Selected.

III. STAFF
- A. 1. Adequate in number, 2. Fair, 3. Inadequate.
- B. 1. Different "schools of psychiatry," 2. Totally one, 3. Variable.
- C. 1. Full-time active leader, 2. Part-time, 3. Consulting "leader."
- D. 1. Administrative and therapeutic responsibility combined in one leader, 2. Part separate, 3. Totally separate.
- E. 1. Little change in personnel, 2. Variable, 3. Much change.
- F. 1. Collaboration with other disciplines, 2. Occasionally, 3. None.

IV. THERAPY
- A. 1. Daily community meetings, 2. Meetings two or three times weekly, 3. Meeting once a week.
- B. 1. Meetings held where patients live, 2. Variable, 3. Away.
- C. 1. Meeting attended by all patients, 2. Variable, 3. Permissive.
- D. 1. Non-use of seclusion room or restraints, 2. Occasional or variable, 3. Common use.
- E. 1. Leader trained and experienced psychiatrist, 2. Psychiatrist's initial independent hospital experience, 3. Variable.
- F. 1. Daily staff meeting, 2. Two or three times a week, 3. Once a week.
- G. 1. Rare use of sleeping pills, 2. Occasional, 3. Frequent.
- H. 1. Ataractic drugs/barbiturates infrequently used, 2. Variable, 3. Relied upon heavily.
- I. 1. Relatively free communication among staff, 2. Variable, 3. Limited.

V. RESEARCH AND EVALUATION
- A. 1. Personal follow-up with or without questionnaire, 2. Variable or questionnaire alone, 3. None.
- B. 1. Ample written documentation kept current, 2. Variable, 3. Inadequate.
- C. 1. Planned periodic use of "neutral observers," 2. Unplanned "neutral observers," 3. Other.
- D. 1. Absence of hidden recording or observation devices, 2. Variable, 3. Devices used constantly.

VI. LEGAL STATUS OF PATIENTS (types of commitment, voluntary status, other legal matters).

In terms of the 32 points of identification proposed here, the type of therapeutic community conducted at Oakland would appear as follows:

Facilities: One ward; locked; fair physical facilities; near populated place; special psychiatric hospital; poor recreational and occupational facilities.

Patient Sample: Unselected; sex—unmixed; race/creed—mixed; economic/social status—mixed; number—12 to 34 patients; diagnoses—mixed.

Staff: Fairly adequate in number; one doctor; full-time active leader; administrative and therapeutic responsibilities combined in one leader; variable amount of personnel turnover; collaboration with other disciplines.

Therapy: Daily community meetings 6 days a week; meetings held where the patients lived; meetings attended by all patients; non-use of seclusion room or restraints; leader trained and experienced psychiatrist; daily staff meetings; rare use of sleeping pills; ataractic drugs and barbiturates infrequently used; relatively free communication among staff.

Research and Evaluation: Personal follow-up of patients on other wards when on duty as Officer of the Day every 8 days, and from hospital records at time of discharge; ample written documentation kept current; planned periodic use of "neutral observers"; absence of hidden recording or observation devices.

No patients were committed, yet because of their service status none were free to leave.

If the same identifying process were applied to another therapeutic community, a totally different pattern might be shown. For example in comparing 4 therapeutic community projects—the Oakland program and 3 others—I found agreement among them all on only the following points in this scale: II (C), Race/creed-mixed; III (C), Full-time active leader; IV (I), Relative freedom of communication; and V (D), Absence of hidden recording and observing devices.

Obviously, then, the scientist is on treacherous ground if he assumes that all therapeutic communities are the same thing. They differ; and unless the type of community to which we refer is clearly identified in each instance, no accurate and meaningful comparison of observations is possible.

A THERAPEUTIC COMMUNITY IN ACTION

In its report *The Community Mental Hospital,* the Expert Committee on Mental Health of the World Health Organization states: "The most important single factor in the efficacy of the treatment given in a mental hospital appears to the committee to be an intangible element which can only be described as atmosphere"(35).

Perhaps the best way to show that this "intangible element" can be produced by very tangible means is to describe a therapeutic community in action. For the 10-month period from July 1955 through April 1956, the locked admission ward of the psychiatric treatment center at the U. S. Naval Hospi-

tal, Oakland, California, was operated experimentally under my direction as a therapeutic community. It is this experiment that I shall describe here, which is modified from many observations in the literature(2, 3, 10, 13, 14, 16, 18, 19, 20, 21, 22, 26, 27).

With certain modifications necessitated by a military culture, the program administered at Oakland was patterned largely upon the well-known projects of Jones, Main, and Rees, whose work I had observed while on temporary Naval duty in England (29, 31). The fact that it was conducted in a military society, with its patriarchal authority and rigid hierarchical system, did not seem to be a detriment to the effectiveness of the program. On the contrary, the natural group belongingness, the habit of working together against common enemies, and the strong emphasis on social environment(16) which characterize the military organization were factors that could be advantageously utilized. It is of historical interest, also, that the therapeutic communities now operating so successfully in England grew to a large extent out of the wartime experience of psychiatrists in military hospitals.

It is significant too, that in the oldest authoritative society in our culture, the military, the conditions necessary to the effective operation of a therapeutic community program were made possible. I was given considerable freedom in the conduct of the experiment, and the program was supported at all levels of command. At the conclusion of the 10-month experiment at Oakland, I was assigned to the Naval Medical Research Institute at Bethesda, Maryland, for one year with no responsibilities other than the evaluation of the data, (some 15,000 typewritten pages of data, 133,000 feet of sound motion picture film, and 40 hours of tape recorded meetings) [4] some of which I shall now present.

Patients remained on the admission ward for only 10 days, then were transferred either to an open or closed ward. They were followed on the other ward when I was officer of the day for the entire psychiatric service, and in the weekly meeting I held with all nurses from all wards. The chief psychiatric nurse for the service attended all of our meetings and in the staff meetings reported on the progress of the patients after they left. In addition we studied the final records of the patients at the time of discharge. Beyond this there was no follow up.

[4] Results of this study to appear in monographs "Social Psychiatry in Action," Charles C Thomas, Publisher. And "Practical Social Psychiatry," Naval Medical Research Inst., Bethesda, Md.

PATIENT SAMPLE

During the 10 months of the Oakland experiment, 939 patients (all of them male) were admitted to the 34-bed locked ward on which the program was conducted. They came, singly or in groups, from west coast hospitals, from ships of the Pacific fleet and islands of the Pacific, and from Naval and Marine posts of duty in the Far East. Many of them arrived in restraints and under heavy sedation. All remained on the ward for an arbitrary period of 10 days before being transferred to other psychiatric wards for intensive therapy. The Oakland Hospital is one of the 2 designated psychiatric treatment centers in the Navy, and hence received the most disturbed patients.

The patient sample was truly a *given sample,* unselected and diagnostically mixed. According to the final diagnoses arrived at in the hospital, 44.4% of the group were psychotic, 26.6% psychoneurotic, 28.3% suffered from character and personality disorders, and 0.7% from acute situational maladjustment. The latter group is not included in the first diagram so that the total is not 100%.

A detailed statistical analysis made of 576 representative cases revealed the following additional factors about this smaller patient sample: [5] 68.7% of the men were Navy personnel and 31.3% Marine Corps personnel; 47.9% had been admitted from shore duty within the United States, 33.9% from ships at sea, and 18.2% from foreign shore duty stations; 3.5% were officers and the re-

[5] The smaller sample here was subjected to many types of analysis, to be reported later in a monograph. As a test of its representativeness, it was compared with the total 939 in terms of diagnosis (psychotic and nonpsychotic); the Chi^2 results suggest that it was almost 100% representative ($.98 < P > .95$).

mainder were enlisted men (rated and unrated) or rated chief petty officers. The median age (officers and men) was 24 years, and the median length of service 3 years. In marital status, 64.3% were single, 30.9% married, and the remainder separated or divorced. Serious suicidal attempts had been made by 11.3% of the men immediately prior to their hospitalization. At the end of their stay on the wards to which they were transferred from the admission ward, 31.9% were still considered 100% disabled and eligible for transfer to Veterans Administration hospitals; 17.2% were ultimately returned to duty, and the rest were separated from the service.

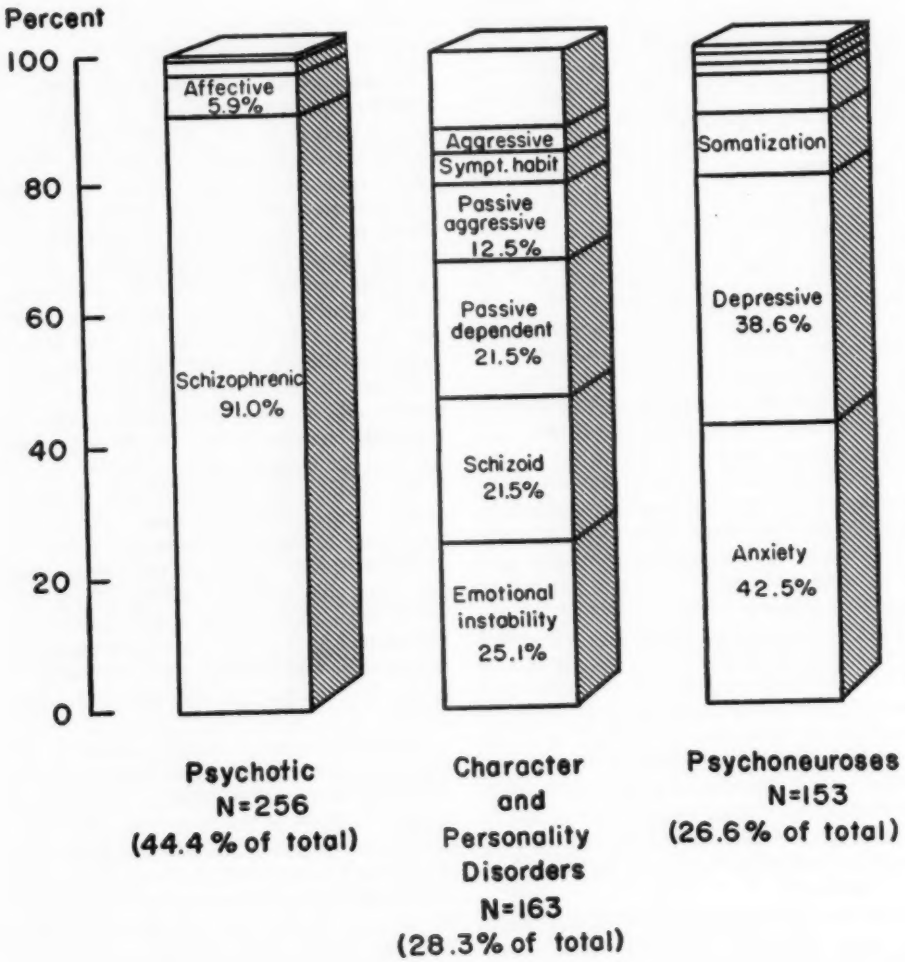

DIAGRAM SHOWING RELATIVE PROPORTIONS OF PATIENTS IN MAJOR DIAGNOSTIC CATEGORIES

FIG. 1.

THE STAFF

The staff, like the patient sample, was unselected. I was the medical officer on the ward, and my responsibilities included both psychotherapy and administration. The organizational plan at Oakland provided billets for 2 full time nurses and 9 corpsmen on the admission ward. This number was not increased for purposes of the experiment, and all staff assignments continued to be made by routine methods. In the normal turnover and rotation, the 9 corpsman billets on the ward were filled by 49 different persons during the 10-month period of the experiment. At one time we were so short of corpsmen that for an unusually busy week the patients could not get out into the courtyard.

There was no preliminary period of staff orientation and training. The nurses and corpsmen assigned to the ward learned how to operate in a therapeutic community by a process of on-the-job training.

OPERATIONAL PLAN

The ward log shows that, until the therapeutic community plan was introduced, there had been numerous incidents and crises on the admission ward. Restraints, isolation, and barbiturates had been the principal measures for dealing with them. On my rounds as OD, I had often seen patients in the ward's two "quiet rooms," calling out loudly, pounding on the door, lost in utter confusion, or mute and motionless on the floor—a picture familiar to all psychiatrists. And I had puzzled increasingly over what possible therapeutic value such methods could have.

The therapeutic community experiment began one day with an announcement to the staff of the general plan and the issuance of the following initial instructions: 1. no form of mechanical restraint was to be used on the ward; 2. the use of the seclusion room was to be discontinued; 3. the barbiturates were to be administered only under unusual circumstances. The general plan provided that ataractic drugs would be used, though sparingly at first, and that electric shock would be recommended if needed (it was used only once on the admission ward, but recommended for several severely depressed patients when they were transferred to other locked wards).

Elimination of Restraints and Seclusion Room.—No mechanical restraints were used on any patient in the therapeutic community, and no member of the admission ward staff ever isolated a patient in the seclusion room. (On 5 occasions, patients were placed in the seclusion room by officers of the day, but they were removed the next morning when I returned to work.) Even with the suicidal patients the time-honored practice of isolation for "safe-keeping" was not observed. Nor were "suicidal precautions" ever "ordered" for any patient. The risks of individual patients were discussed at the daily staff meetings; but the staff learned by actual experience that the suicidal patients were safer on the ward, with the attention of others, than in the seclusion room and that they also seemed to get well faster there, at least symptomatically.[6]

Use of Drugs.—The number of barbiturates prescribed dropped precipitously (Figure 2). In the last 4 months of the experiment, only 24 doses, oral and parenteral, were given to the 443 patients admitted to the ward during the period. This contrasts with 314 doses given to 400 patients admitted during the 4 months prior to the establishment of the therapeutic community. Sleeping pills were found to be largely unnecessary (30).

Our use of ataractic drugs (chlorpromazine and reserpine) ranged from 4.4% of the patients in the first month of the experiment to 31% in another. In the first 4-month period, 10.8% of the patients were given these drugs. In the second 4-month period, the proportion was increased to 27.9%, to determine whether a more extended use of ataractic drugs would further benefit the community and also because in the last 4 months an open receiving ward was established so that the less disturbed patients were not admitted to our ward. (In both periods the same average dose was used—chlorpromazine, 100 mgs; reserpine, 1 mg. The average number of doses per patient treated, remained about the same, 16.0 in

[6] We were always aware that a grave emergency could occur in which the quiet room might be necessary. This would have merely been an exception to the rule but during the time of the experiment it did not occur.

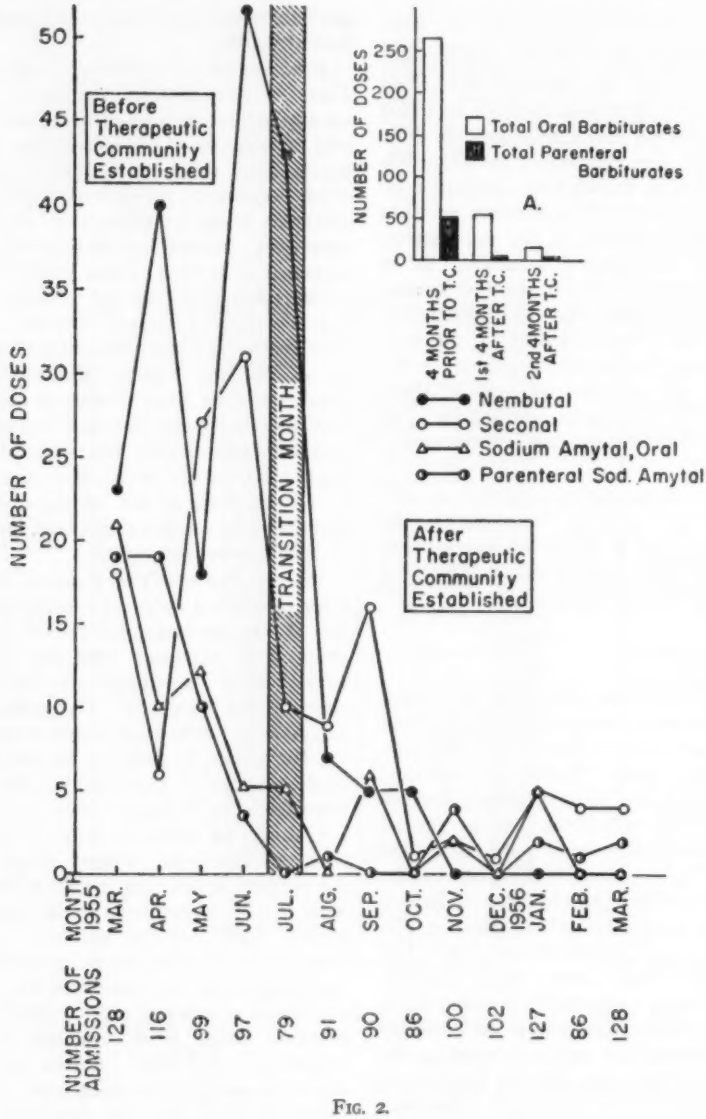

FIG. 2.

the first 4-month period, and 15.7 in the second.)

The number of patient problems and administrative and behavioral difficulties during the second of these 2 periods showed no significant decrease over the first, although the proportion of patients treated with ataractic drugs was almost 3 times greater. The difference is satistically significant at the 1% level ($.001 < P > .01$). Subjective observations led to the conclusion that extension of the ataractic drug treatment made no appreciable over-all difference on the ward. This may suggest that the drugs have a discernible but limited value. We found them of real benefit in dealing with the most hyperactive cases, particularly with the hebephrenic and manic patients and the greatly

disturbed paranoid schizophrenics. With the less "actively" ill, their value was slight. It was our conclusion that, as with the use of sleeping medication, the extensive use of ataractic drugs was neither necessary nor profitable to the therapeutic community. Patients were allowed to have a degree of anxiety, which was utilized in helping them master their problems of hospitalization.

Community Meetings.—Six days a week, after the morning sick call, the patients and staff gathered together on the ward for a 45-minute meeting. The patients would take their bedside chairs and place them wherever they wished to sit; I always sat in the same chair by the foot of a bed in the middle of the ward; and the staff dispersed themselves throughout the patient group.

It was clear to the patients that whatever they wanted to talk about in these meetings was permissible. During the course of the 10 months the discussion ranged over a wide variety of subjects. It was always allowed to take its direction largely from the patients themselves. I made a minimum number of interruptions and interpretations and in the last few minutes of the hour summarized the meeting. The major therapeutic contribution was made by the patients themselves(33).

All patients were *expected* to attend the meetings. They were not forced to do so, and no "or else" was implied. But the firm expectation alone was sufficient so that only 2 out of 939 patients on the ward during the period of the experiment refused to attend.

Staff Meetings.—As a part of the on-the-job training process, 30-45 minute staff meetings were held in my office 6 days a week immediately following the community meeting. Problems on the ward were taken up at this time, and the community meeting that had just ended was analyzed in detail for the information that it had revealed about each of the patients, the community as a whole, and the staff as well.[7] These meetings proved to be highly effective for developing the staff attitudes which must exist if the therapeutic community is to succeed.

The morning and afternoon corpsmen shifts alternated with each other, thus the day crew would all have an equal opportunity to attend the meetings. The night crew, however, was constant; so I met with them separately for 30 minutes on the nights when I was OD once a week. In addition I met once a week with the nurses and once a week with the corpsmen.

Interviews with Patients.—Each patient was seen briefly by me within an hour after his admission and in a 30-60 minute evaluation interview within a day or two. If any of them desired further interviews, this could be arranged simply by signing their names on the "doctor's list" posted on the bulletin board. They were seen strictly in the order in which their names appeared on the list, and within 48 hours. During the 10 months of the experiment, ⅔ of the patients signed the list; of this number, 48.6% requested only one interview. In terms of the major diagnostic categories, the relative distribution in this group paralleled within 2.8% that in the total patient sample. No major diagnostic category was disproportionately represented in the group of patients who requested interviews.

In addition to these general arrangements for interviews, one "treatment case" was chosen at random each 10-days for continuous therapy in daily 30-minute sessions. This was done to give me a deeper insight into the community processes through the observation of the individual patient.

RESULTS

One of the aims of the therapeutic community is to foster self-control through a process of socialization. To achieve this, the patients and staff must have a sense of fellow-membership in the community and must make the attitudes implicit in this membership a part of their conscious and unconscious habit throughout the 24-hour day on the ward, all of which is considered therapy. This places upon both a mutual responsibility for courteous and helpful behavior in all staff-patient and patient-patient relationships. It fosters relatively free and full

[7] Situations of this kind afford an opportunity for patients and staff. In psychiatry we have to accept responsibility for the mental health of the relatively untrained personnel and such meetings provide the fundamental aspect of staff training. Not only was the treatment situation for the patients dealt with but also the staff tensions activated in the process which must be resolved before therapy can be dealt with objectively.

communication by patients and staff with a continuous feedback of information and endless observations by community members.

The experiment at Oakland, I believe, largely fulfilled this aim: as behavior improved discernibly, and acts of violence practically disappeared; incontinence was rare; and even the psychotic patients were accepted into the community meetings and often functioned exceedingly well, sometimes showing dramatic symptomatic improvement in a matter of days. We were encouraged to undertake the socialization of "psychopaths" by the experience reported by Jones(12).

The effect of the community meetings carried over also to the more important other 23 hours of the patients' day. Observers who remained on the ward during the entire day were able to report a continuous and rather sophisticated discussion, usually stemming from the morning's community meeting, which helped to relieve the inevitable monotony of life on the ward. The patients read, played cards or ping pong, exercised together in the courtyard, organized games, or formed small groups among themselves. The ward had, in fact, become a social community.

The staff at first were apprehensive at the prospect of dealing with the patients without the familiar mental hospital procedure of imposed controls. But gradually, through a process of "learning by doing," they were largely relieved, at least consciously, of their fear that they could not cope with the patients by the methods permitted to them in the therapeutic community. And, with the patients largely relieved of their fears of harsh treatment, a spirit of mutual cooperativeness and trust developed. The *firm expectation of socially acceptable behavior,* without an "or else" implied, paid dividends.

This is not to say that no difficulties and problems arose in the therapeutic community, but only that most of them were met in a cooperative community spirit and that most of them were mastered.

Summary

The therapeutic community concept is only one of many new approaches to the problem of the mentally ill. But it is a hopeful method, and one that can lead, I believe, to the improvement of our mental hospitals. How much its success depends upon the enthusiasm, optimism, and enhanced interest and activity of the staff is difficult to evaluate. The immediate task facing those of us who believe in its efficacy is, as I see it one of making the intangible atmosphere tangible—descriptively, statistically, and graphically—so that the failures and successes with the therapeutic community approach can be analyzed and the procedures perfected. We need to work toward a clearer understanding of what this method is, psychologically, psychoanalytically, and psychiatrically; to identify, define, and study significant elements of the therapeutic milieu as objectively and critically as possible. We need work like the paper of Ackner, Harris, and Oldham(1) in which scrupulous controls are established in the evaluation of treatment programs with proper consideration of therapy and socio-environmental factors with elimination of staff attitude from the final judgments.

The therapeutic community here described represents an effort at the understanding of *patient management.* It is my impression that it is also therapy but this has not been proved. The "traditional role of the patient is to be sick" but in this ward the role of the patient is to exhibit normal behavior as nearly as he possibly can. Management of the acute psychiatric patient was based on the expectation of self-control rather than the traditional staff attitudes that patients were "dangerous" and would momentarily go out of control. With a sharing of responsibility and participation in the over-all program (within the limitations of the military hospital structure) according to the capabilities of the patients the expectations were now based on actual happenings rather than projected fears. This type of management opens up the possibilities of therapy through social interaction with the staff-patient involvement affording potentialities for social development and identification with the group. It also focuses attention on treatment at the beginning of hospitalization (in an admission ward) which is a necessary parallel to studies of therapy and patient management, resocialization and re-

habilitation of the long-term patient. It is also, in a sense, part of the same problem and could ameliorate the magnitude of the enduring hospital problems in patient management.

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DISCUSSIONS

MORRIS WEISS, M.D. (Northville, Mich.).—In our own experience of attempting to establish a therapeutic community in a 40-bed closed section in a General V.A. hospital it took at least several months before certain crucial changes could be made. It was difficult for certain staff members to give up their traditional roles. Freer communication between staff members, let alone toward patients, was not easy to establish. The allowing of patients greater participation and decision in their treatment and hospital life was met with resistance. The staff needed to be worked with and supported initially.

For some of our schizophrenics—and this category comprised 70% of our population—the therapeutic community can be a threat as well. The

meaningful involvement of the ambulatory schizophrenic in such a program was our most challenging task. In the schizophrenic there is a tendency to give up normal social roles for the security operations employed in his illness. His relative isolation and need to remain passive militate against active participation. Thus, we accepted the idea of the patient determining the level of his own participation and responsibility within community affairs. Approved social behavior and roles he learned from more intact patients and staff. What may be a therapeutic community for the personality disturbance or neurotic may not be for the schizophrenic.

The importance of the community meetings cannot be overestimated. In our community meetings it was felt that free discussion would lead to a group decision and then to some appropriate action if this was called for. We felt that when a concrete result followed—when, for example, an unnecessary bed time rule was changed or more benches installed in the shower room—the patients felt that their words had meaning and that discussion could lead to favorable changes. This gave substance to the feeling that treatment was patient oriented.

In describing his results Dr. Wilmer states that the patients and staff developed a sense of membership in the community. To explain it he says that there was a carryover for the rest of the day from the morning community meeting. My guess is that membership spirit resulted from something additional. The doctor's own energy, encouragement, and investment in the program can become contagious. Also, there probably was much informal interaction and socialization staff to patient, and patient to patient. It would be nice to have had a description of such interactions as these can be quite significant in the therapeutic community.

The author presents an outline for comparing therapeutic communities. Dr. Wilmer will perhaps agree that a more detailed and comprehensive description of the formal and informal structure of the community will develop. Studies like Devereux's in which he describes the social pattern of a schizophrenic ward or Henry's account of types of institutional structure and how they profoundly influence the milieu come to mind.

I think Dr. Wilmer deserves much credit for his continued search to make "tangible" the essential attributes of the therapeutic community, and we shall look foreward to his future reporting as more data are analyzed.

ROBERT A. MATHEWS, M. D. (Philadelphia, Pa.).—I like this paper because Dr. Wilmer has done something that needed doing and has done it well. He puts it aptly when he says the therapeutic community may use all types of therapies "but its basic therapy is milieu therapy—its efforts are not dictated by "humanitarian" purposes but by therapeutic purposes which are humane—it imposes limits on certain forms of behavior, initiating these limits from the members whenever possible—it fosters by every possible means an environment without fear or distrust in which patients feel safe and in which communication is relatively free."

As so clearly demonstrated by Dr. Wilmer, a ward conducted as a therapeutic community becomes a social tranquilizer. Here is an acute service with all types of patients who interact in a therapeutic fashion practically without sedation or restraint. It represents patient management without fear. Why? Because the staff is not afraid of the patients so the patients take their cue from the staff and are not afraid of each other or the new patient who acts in a threatening way.

Dr. Wilmer has also demonstrated that such a therapeutic community can be established and conducted successfully in a rather rigid authoritarian administrative structure such as a military medical service. This being the case it becomes obvious that the same principles and patterns can be adapted to our large state mental hospitals, to private mental hospitals and to psychiatric works in general hospitals. The latter facilities are rapidly becoming the focal points for initial residential treatment in community centers and mental health programs. Having as yet no structure fixed by tradition, these units can most readily adapt to and apply the concepts outlined in this paper.

CLINICAL NOTES

A CONTROLLED STUDY OF THE HABIT FORMING PROPENSITIES OF MEPROBAMATE

JOHN A. EWING, M. D., D. P. M.,[1] AND THOMAS M. HAIZLIP, B. S.[2]

In view of the importance of this subject we are submitting this brief preliminary report.

The earliest reports on meprobamate ("Miltown," "Equanil") stated that the drug was not habit-forming(1, 2). More recently a number of reports have described undesirable side effects as well as instances of excessive self-medication(3).

Probably all drugs used to sedate or to tranquilize can be habit-forming, the patient becoming psychologically dependent upon an effect such as a sense of relaxation or well-being. Of course it is clear that certain patients may develop a dependence upon a non-active drug if there is a suitable psychological meaning of that drug for the patient.

Ewing and Fullilove(3) described a case in which the patient seemed clearly to develop a physiological dependence, and during the first 6 months of 1957 we heard of other instances and observed further examples which suggested to us that a physiological tolerance to meprobamate can occur and that there can be a withdrawal syndrome.

This observation we put to the test in July and August 1957. Seventy-five chronic but cooperative State Hospital patients without history of convulsions were divided randomly into 3 groups. A "double blind" study was conducted with groups of 25 patients receiving respectively identical placebos throughout or meprobamate 6.4 gm. daily or meprobamate 3.2 gm. daily.

Clinical observations and classification as regards the effects of meprobamate and withdrawal reactions were completed before the code was broken. This revealed severe sedative effects at those dosage levels.

During the first three days 35 patients out of 47 showed staggering gait or inability to stand or walk without falling. Other effects included projectional vomiting (4 cases), and urinary and fecal incontinence (4 cases).

After 7 to 10 days most patients were no longer excessively sedated, pointing, we believe, to the occurrence of physiological tolerance.

The three patient groups were continued on the meprobamate or placebos for 40 days at the end of which time all patients were switched to placebo. Clinical observation revealed objective evidence of an abstinence syndrome in 44 out of 47 patients who were previously on meprobamate. Two patients who received placebo throughout (of a total of 24) were suspected of showing an abstinence syndrome because of insomnia alone.

The typical meprobamate withdrawal syndrome included various degrees of insomnia, vomiting, tremors, muscle twitching, overt anxiety, anorexia and ataxia. Eight patients showed a picture of hallucinosis with marked anxiety and tremors much resembling delirium tremens. Three patients developed grand mal seizures.

The effects and the withdrawal syndrome of meprobamate at both dose levels are statistically significant when compared with placebo in this study. We hope to publish the actual figures and further details as soon as possible.

Meanwhile, we feel justified in concluding that meprobamate closely simulates the barbiturates. It would therefore seem wise to start the drug slowly and to discontinue it slowly in order to prevent the occurrence of withdrawal symptoms.

A more refined study of this problem is planned and will be reported when completed.

We are grateful for the support of Wyeth Laboratories and for the cooperation of the Superintendent and staff of the State Hospital at Raleigh, N. C.

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VASOLASTINE IN THE TREATMENT OF ARTERIOSCLEROSIS

A. J. NOORDSIJ, M.D.,[1] AND JACKSON A. SMITH, M.D.[2]

A preparation (Vasolastine[3]) containing a rather formidable number of lipotropic enzymes, as well as two proteolytic enzymes active in the metabolism of amines, was evaluated clinically following an earlier animal study.

These enzymes are obtained from Crucifer seeds and contain the following systems: fatty acid activator, co-enzyme A, acyl dehydrogenase, cleavage and condensing enzymes, adenosine triphosphate, dephosphopyridine nucleotide, and cholesterol esterase; in addition, amino acid-oxidase and tyrosinase-tryptase were included.

This study was initiated following encouraging therapeutic reports in the literature.

Twelve patients were included in this series; 6 were diagnosed chronic brain syndrome associated with cerebral arteriosclerosis, the other 6 were classified as chronic brain syndrome associated with senile and presenile brain disease with circulatory disorders. The patients were transferred either from an admission ward or from a state hospital to a research ward. Personnel were available to provide special occupational and recreational therapy for a geriatric group. The nursing care was sufficient to train and encourage the patients to fit into an active ward routine. The preparation was given intramuscularly over a period of 30 to 90 days in a dosage of 2 cc. three to seven times a week.

In addition to repeated psychiatric evaluations, physical and neurological examinations, and psychological testing, roentgenograms of the thorax, electrocardiograms and electroencephalograms were made at regular intervals. Blood pressure readings were recorded daily. Urinalyses, complete blood counts, and blood sedimentation rates were done routinely. Serum cholesterol and lipoprotein determination were carried out.

The medication was well tolerated; the only undesirable side effect was a leukopenia which occurred in one patient after 30 days of treatment, with a prompt recovery following discontinuation of the medication.

Behaviorwise, the results were encouraging since the majority of the patients in both diagnostic categories showed more interest in self and in their environment. Subjectively there appeared to be an improvement in mood with a decreased frequency of somatic complaints. The patients' relatives were encouraged by the change in the patients' appearance and showed an increased interest, visited more frequently, and became more accepting of the patient. In 4 cases this led to the patients being either returned to the home or being placed in a nursing home rather than being returned to the state hospital.

Objectively, there were no significant changes in any of the measures taken. Arteriosclerosis as measured by lipoprotein and cholesterol determinations was not materially affected by the preparation. It was concluded that the desirable behavioral changes observed resulted from the increased care, attention and activity following transfer to the research ward, rather than a specific effect of the preparation being administered.

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[2] Director of Research, Nebraska Psychiatric Institute, Omaha, Nebr.

[3] This preparation was generously supplied by Polypharm N.V. (P.B. 6025, Rotterdam, The Netherlands).

SIMPLIFYING CHLORPROMAZINE MAINTENANCE THERAPY

ELSE B. KRIS, M.D.[1]

Clinical experience has demonstrated that certain patients treated with chlorpromazine during their hospital residence, require maintenance therapy when returned to the community in order to prevent a relapse. Such maintenance therapy has proved to be necessary in those cases where the duration of illness is a longer one. Some cases, however,

[1] Aftercare Clinic, 2 West 13th St., New York 11, N. Y.

although of a more acute nature, still require maintenance therapy if the stress situations in the environment are considerable. It has been observed in general that the excitement of coming home and having to adjust to the outside world is frequently better tolerated, even in acute cases, if maintenance therapy is started for at least the first few weeks after which it can be discontinued.

Patients who have had a longer duration of hospitalization, or those who had several hospital admissions, require to be kept on a maintenance dosage as they otherwise show, sooner or later, recurrence of symptoms.

Such maintenance therapy has to be individually adjusted to the needs of each patient and continued in some cases for a prolonged period of time, in some others indefinitely.

It was occasionally observed that patients starting employment are under considerable tension which might interfere with their sleep. Here, too, maintenance therapy over the first few weeks helps a great deal in work adjustment.

In all these cases it was found that patients who returned to the community and were on medication more than once or twice a day would either forget to take the medication or would feel embarrassed by having to take it while being watched by others at work or socially. Taking pills on the job left the patient open to questioning and involved uncomfortable explanations or evasions. To avoid this the use of a sustained release capsule containing chlorpromazine, the spansule form of the drug, which provided medication for a period of about 12 hours with one dose, has been tried. This enables the patient to omit the inconvenience of the midday dose and also insures a more even distribution of the effect of the drug.

Moreover, it has been observed in a number of cases that this method of chemotherapy has a beneficial effect on the patient's sleep cycle. This was particularly true in those patients who previously had complained while receiving regular chlorpromazine medication at hour of sleep, about nightmares, particularly prominent during the hours of waking early in the morning. These patients, when receiving the spansule form of the drug at bed-time, reported that they now were able to sleep soundly all through the night and no longer were disturbed by nightmares.

THE COMBINED USE OF A TRANQUILIZER,[1] SYMPATHOMIMETIC AND VITAMINS IN THE TREATMENT OF ELDERLY PSYCHOTIC PATIENTS[2]

LIONEL H. BLACKMAN, M.D.,[3] ABRAHAM GLENN, M.D.,[4] AND LEON OLINGER, M.D.[4]

Our recent study at Brooklyn State Hospital considered one of the major problems in psychiatry today, namely: the treatment of the aged psychotic patient. Physical debility was taken as a major consideration as well as psychiatric symptoms and sensorial changes.

The medication used was a combination of previously proven therapeutic ingredients now combined to modify and eliminate undesirable side effects. A therapeutic dosage of vitamins was utilized in consideration of the patients' nutritional state. Reserpine(1), one of the best tranquilizers, was employed to reduce agitation and anxiety; d-amphetamine sulfate was employed as a psychomotor euphoriant to prevent "overtranquilization" often seen with prolonged use of Rauwolfia alkaloids. This preparation, besides giving the expected results of each of the constituent drugs, seemed to suggest a clinical synergism.

A total of 140 elderly psychotic patients

[1] A combination of reserpine, d-amphetamine sulfate, and a therapeutic vitamin formula. This preparation was developed and supplied by Premo Pharmaceutical Labs., Inc., 111 Leuning Street, South Hackensack, N. J., under the name Vita Respital.

[2] The authors wish to express their appreciation to Dr. N. Beckenstein, Senior Director of Brooklyn State Hospital, for his cooperation in making this project possible, and Dr. H. Perlowitz for his valuable work on controls.

[3] Lakeville Medical Center, New Hyde Park, N. Y.

[4] Supervising Psychiatrists at Brooklyn State Hospital, Brooklyn, N. Y.

were used in this study. The ages varied between 47 and 95, averaging 70. The diagnoses were as follows; senile psychosis 71, psychosis with cerebral arteriosclerosis 28, dementia praecox 10, manic depressive psychosis 6, involutional psychosis 19, psychosis due to syphilis 3, alcoholic psychosis 2, posttraumatic psychosis 1. All of these elderly psychotic patients had a relatively poor prognosis and were unlikely to reveal any sudden changes.

The medication which consisted of a therapeutic vitamin formula, reserpine .25 mg. and d-emphetamine 5 mg., was administered three times a day. The group of patients was divided into two main subdivisions, 73 of whom received the medication and 67 of whom received placebo. A double blind technique was utilized so that neither the individuals administering the drug nor the patients knew who was getting medication and who was receiving placebo. The placebo and drug appeared identical.

Our studies ran for a total of 10 weeks. Each item in the protocol was graded as follows: 3 plus—greatly improved, 2 plus—moderately improved, 1 plus—slightly improved, 0—no change. All improvements were then added and contrasted with the results of the placebo group. A summary of our findings showed the following improvements (figures for the control group in parentheses): Nutrition, 86% (19%); Sphincter Control, 27% (8%); Muscle Strength, 39% (30%); Sociability, 67% (30%); Cooperation, 50% (10%); Activity, 56% (17%); Initiative, 45% (13%); Self-Care and Appearance, 41% (10%). No side effects were noted and there was very little fluctuation in blood pressure.

The new drug presented, a combination of reserpine, dextro-amphetamine sulfate and therapeutic vitamins was a logical combination of previously proven therapeutic ingredients which have been utilized in treating many of the symptoms of the geriatric patient. Clinical observations seem to indicate a synergistic action, perhaps because the improvements of the patients' physical debilities enhance utilization of the dextro-amphetamine sulfate and the reserpine, or perhaps because the improvements in the patients' mood and cooperation due to the dextro-amphetamine and reserpine enable them to better metabolize their nutriment. The resultant improvements become more significant in their import when we consider the double blind placebo technique utilized. We feel these results are most encouraging for further use of the drug in elderly psychotic patients, and for the geriatric patient seen in private practice(2), who perhaps is not so severely ill as the hospitalized patients in our study.

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CLINICAL NOTE CONCERNING IPRONIAZID (MARSILID)

ROBERT R. SCHOPBACH, M. D.[1]

In an effort to determine the efficacy of iproniazid in the treatment of depressions, it has been administered to selected cases and compared with the effects of other medications as well as with a placebo. Although it is recommended to elevate mood and to stimulate appetite, it was not used in the severely depressed individual where electroshock therapy is known to be very efficacious. It was given concurrently with electroshock therapy in a number of other cases. It is impossible to accurately estimate its effects separately, but it was the impression that it did exert a beneficial effect upon the mood of the individual, both during and subsequent to the treatments. There are, however, many individuals who are depressed to a lesser degree, but whose adjustment and enjoyment of life are impaired. The group reported here is comprised of 15 such ambulatory depressive patients. The initial dose of the medication was 50 mgs. 3 times a day. This was given without any "sales talk" or comment other

[1] Henry Ford Hosp., Detroit, Mich.

than "I think this medicine may help you." After 2 to 4 weeks the dosage was reduced to 25 mgs. 2 to 3 times a day, and after 2 or 3 months this was gradually discontinued. Beneficial effects were reported within the first one to two weeks, and further improvement was noted up until 3 months in some cases. The results are reported as to the degree of improvement and the psychiatric condition underlying the depressive reaction.

Seven showed and reported considerable improvement. Six were chronic neurotics while one was depressed following Rauwolfia therapy and had only partially been helped by Ritalin. One to two months later these patients reported, "I felt like my old self," "vastly improved," or "perfect now."

Three were somewhat improved. Of these one was a neurotic depressive, one a schizoid personality, and one a cyclothymic personality. Eight of these 10 patients showing improvement had not improved on previous placebos or other medications.

Four were essentially unaffected. Two schizoid persons with depression improved, but felt similarly improved by placebos. One with chronic brain syndrome was unaffected by iproniazid as well as by other drugs. One obsessive neurotic became more energetic on the placebo and, in addition, felt less tense when taking the drug.

Only one obsessive neurotic stated that not only was he unimproved but that he also seemed to have less appetite. There were no other complaints of any side-effects and no one discontinued the drug for such a reason.

This group is obviously too small to be statistically significant due to the selection of only moderately depressed individuals and the use of controls. Nevertheless, the results of this 6 months observation suggests that psychoneurotic depressive reactions may be greatly benefited by this medication, whereas the schizoid individuals with depression are not so greatly benefited. This selection of patients may account for the difference in the results reported here, compared with the report of F. J. Ayd (Am. J. Psychiat. 114:459).

TWO YEAR FOLLOW-UP STUDY OF THE RELATIONSHIP OF CHLORPROMAZINE AND THE INCIDENCE OF CONVULSIONS IN FIFTY POST-LOBOTOMY PATIENTS

A. E. PAGANINI, M.D., AND M. ZLOTLOW, M.D.[1]

Epileptic convulsions as a complication of chlorpromazine have been described by many authors(4, 5, 6, 7, 8). This study covers the possible epileptogenic effect of chlorpromazine on 50 post-lobotomy patients treated and observed for a period of 2 years. All of these patients were on the male chronic service of Pilgrim State Hospital and all were diagnosed as chronic schizophrenics. All of these patients had been continuously hospitalized since their lobotomy which was done at least 2 years prior to the onset of the study by the same neurosurgeon using the same classical technique.

Twenty-five post-lobotomy patients who had convulsions at one time or another were compared with 25 post-lobotomy patients who had not at any time had convulsive seizures. Chlorpromazine was given to both groups. All of the first group (convulsive group) were continued on predetermined optimal anti-convulsive medication while the second group (non-convulsive group) received no added anti-convulsants. The only change in the routine of the patients involved in the study was the addition of chlorpromazine in doses varying from 200 to 800 milligrams daily.

RESULTS

In the first group of post-lobotomy patients, that is, those who had seizures at one time or another before chlorpromazine, 9 continued to experience seizures after the institution of chlorpromazine. In 5 of these patients, it was noted that the seizures had occurred as recently as 3 months before the institution of therapy and occurred 2 to 4 weeks after the institution of chlorproma-

[1] Pilgrim State Hospital, West Brentwood, N. Y.

zine therapy. Two of these 5 patients developed a status epilepticus late after the institution of chlorpromazine; one of which had never had "status" before. It must be emphasized that the rest of the patients in this group, that is, 16, did *not* develop convulsions at any time even after the sudden withdrawal of chlorpromazine. It must also be emphasized that all in this group continued on anti-convulsants, and none was considered well enough for release on convalescent status. In the second group of post-lobotomy patients, that is, those who at no time had any convulsions, *no* convulsive seizures developed during 2 years of observation. None of the patients developed fits after the sudden withdrawal of chlorpromazine. None was given anti-convulsants at any time. However, one of these patients died suddenly. No autopsy was performed and the assumption was made that the patient sustained an acute coronary occlusion although the remote possibility of a "masked fit" was entertained. This constituted the only questionable convulsion which occurred during chlorpromazine therapy in this group. Two of the patients in this group were released on convalescent status and to date are making a satisfactory social adjustment.

DISCUSSION

Initially, the impression was gained that chlorpromazine was epileptogenic because of isolated instances of convulsive seizures developing after the institution of therapy. It was speculated that the scar produced by the lobotomy was enough to predispose a patient to develop fits and that the drug acted as a trigger. However, as the study progressed, it became obvious that only in those patients who had had convulsions prior to the institution of chlorpromazine did convulsions develop and then in only 9 of the 25 patients. Even in these 9, the number of fits seemed to diminish the longer the chlorpromazine was continued. Also, it was felt that the anti-convulsants should be continued at the previous optimal levels in order to give the patients maximum protection from the development of an increase in convulsions. In only one instance where a status epilepticus developed in a patient who had previously never had one was there a question as to the worsening of the patient as far as epileptic convulsions were concerned. Even in this case, however, chlorpromazine is still continued with caution but without fear. Most important, of the patients who had never had convulsions, despite the absence of anti-convulsants, none developed convulsions while on chlorpromazine, with the possible exception of the case of sudden death which could have been a "masked fit."

CONCLUSIONS

Our 2 year follow-up study of 50 post-lobotomy patients and the incidence of convulsions with chlorpromazine therapy reveals the following conclusions:

1. Chlorpromazine did *not* increase the frequency of convulsions in post-lobotomy patients who have a convulsive background.

2. In post-lobotomy patients who never had convulsions, chlorpromazine *did not* produce convulsions but the possibility of a "masked fit" in one case of sudden death must be entertained.

3. In patients who have a history of convulsions, the seizures seemed to occur within 2-4 weeks of the institution of therapy but the number of fits seems to be decreasing. This may indicate a probable synergistic action between the anti-convulsants and chlorpromazine.

4. Anti-convulsants should be continued while the patient is on chlorpromazine if there is a history of convulsions.

5. In our opinion, there is no contra-indication or risk in the use of chlorpromazine for the relief of psychotic symptoms in post-lobotomy patients providing convulsive patients are continued on anti-convulsants.

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TREATMENT OF PSYCHIATRIC DISORDERS WITH TRIIODOTHYRONINE

FREDERIC F. FLACH, M. D.,[1] CHARLES I. CELIAN, M. D.,[1] AND RULON W. RAWSON, M. D.[2]

Psychopathologic changes have been described in patients with hyperthyroidism and myxedema. Several studies of schizophrenic patients have indicated low basal metabolic rates and resistance to large doses of thyroid hormone. Such observations suggest that, in selected psychiatric disorders, products of intermediary thyroid metabolism, such as triiodothyronine and the acetic and propionic acid derivatives of thyroxin and triiodothyronine, may have beneficial therapeutic effects.

Triiodothyronine was administered to a series of 24 psychiatric patients, 5 male and 19 female, hospitalized at the Payne Whitney Psychiatric Clinic. Three patients were under 20 years of age, 15 between 20-39, and 6 over 40. None demonstrated endocrinologic or cardiovascular disease after thorough physical and laboratory examination. The duration of illness ranged from 4 months to 25 years, with a median duration of 18 months. Seventeen patients were diagnosed as schizophrenic reactions: 5 simple, 5 paranoid, 2 catatonic and 5 undifferentiated. Three were diagnosed as depressive reactions, 2 as paranoid reactions, 1 as a severe, chronic obsessive-compulsive reaction, and 1 as anorexia nervosa with marked obsessive-compulsive features.

The most frequent and marked psychopathologic manifestations in this group included diminished emotional responsiveness associated with lack of spontaneity, apathy and social withdrawal; depersonalization; absence of sexual interest; depression of mood; and specific obsessive-compulsive symptoms.

Oral doses of 100 micrograms of triiodothyronine were administered daily for one week. The dose was then increased to 200 micrograms daily for two weeks, reduced to 100 micrograms daily the fourth week, and subsequently terminated. Headaches and palpitations were the leading side-effects, usually disappearing after the initial week of treatment.

During the study the patients were observed by their individual psychotherapists, research psychiatrists, and the nursing staff who maintain continuous behavioral charts on all inpatients. Of the 24 patients, only 1 did not change. Nine patients demonstrated clinical changes, without significant improvement in their basic psychopathologic conditions. Seven patients improved moderately, and 7 improved markedly. Of the 23 patients who showed some degree of change, 16 changed psychopathologically while receiving triiodothyronine, while 4 did not improve until shortly after the termination of treatment. The remaining 3 patients improved somewhat on the drug, experienced a 5 day period of emotional upheaval immediately after termination, and then proceeded to improve markedly thereafter.

The pattern of emotional change appeared to be well-defined. Uniformly and without exception diminished emotional responsiveness, denial, dissociation of affect and depersonalization were reduced or disappeared entirely, and spontaneous activity increased. Productivity in psychotherapeutic interviews increased substantially. Depression of mood was alleviated in the majority of cases, especially when the increase in emotional reactivity was accompanied by a moderate or marked degree of general symptomatic improvement. Obsessive-compulsive symptoms were significantly reduced. The one case of anorexia nervosa distinctly improved. Most interesting was the observation that more than two-thirds of the patients demonstrated previously hidden or absent sexual feelings and hostile emotions on triiodothyronine. The most marked changes were noted among the schizophrenic and psychoneurotic groups, except for the paranoid schizophrenic reactions. The latter, as well as the paranoid reactions and depressive re-

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actions, did not show any change in their basic conditions, although associated features, such as depersonalization and denial, were reduced.

The mechanism of action of triiodothyronine is evidently complex. Undoubtedly it influences total endocrine balance. It may directly stimulate emotions and instinctual drives, or it may increase alertness and broaden the scope of consciousness, thereby alowing previously repressed or suppressed feelings to reach awareness.

Triiodothyronine appeared to be qualitatively different from and quantitatively more effective than either the acetic or propionic acid derivatives in producing emotional changes. These compounds were studied in a smaller series of patients given doses which calorigenically were only a fraction of the doses of triiodothyronine used.

The clinical use of these thyroid hormones in the treatment of psychiatric disorders must be considered to be in an experimental phase of development. Further experience will be essential to clarify their therapeutic potentials and such technical factors as dosage requirements and optimal duration of administration.

HISTORICAL NOTES

THE FIRST PROFESSOR OF PSYCHIATRY—SAMUEL MITCHEL SMITH

PHILIP C. ROND, M. D.[1]

The American Journal of Insanity, in October, 1847, noted the first appointment of a professor of psychiatry in a medical school in the United States as follows:

> We are gratified to learn that a Professorship of Insanity has been established at one medical school. The Willoughby University, Columbus, Ohio, has appointed Samuel M. Smith, M. D., Professor of Medical Jurisprudence and Insanity. We think there should be a distinct course of lectures on medical maladies at every medical school. Dr. Smith has some practical knowledge of insanity, having been an assistant physician at the Ohio Lunatic Asylum for several years(1,2).

Dr. Samuel Mitchel Smith was born in Greenfield, Ohio, November 26, 1816. The historic, two-story house occupied by his family at the time of his birth still stands. He obtained his early education in private schools and from his father, who was a Presbyterian minister. He obtained his A.B. degree from Miami University, Oxford, Ohio, in 1836. Following this, he was principal of an academy at Rising Sun, Indiana. This position he obtained through the help of his friend William Holmes McGuffey, Professor of Latin and Greek at Miami University and the man whose name was a household word among several generations of Americans because of his authorship of the McGuffey Eclectic Readers.

Dr. Smith read medicine while at Rising Sun under Dr. John Morrison. He attended two sessions of medical lectures at the medical college of Ohio in Cincinnati and obtained an M.D. degree from this college in 1839(3). He enrolled at the University of Pennsylvania Medical School, Philadelphia, in 1839 and one year later, in 1840, received his second M.D. degree.

He came to Columbus in 1840 and took a job as assistant physician at the Ohio Lunatic Asylum (Central Ohio Hospital for the Insane), under the supervision and direction of Dr. William Maclay Awl, (second President of The American Psychiatric Association, 1848-1851)(4). He remained at this position for approximately 3 years, or until 1843 when he resigned to open up a private practice of medicine.

On February 19, 1847, the trustees of the medical department of Willoughby University met in Columbus. They resolved to move the medical department of this university to Columbus, Ohio. They subsequently declared all chairs vacant in the medical department and appointed a new group of men to fill the vacated chairs. Among those appointed unanimously was Samuel Mitchel Smith, M. D., to the chair of Medical Jurisprudence and Insanity.

In 1848 the Starling Medical College was founded (Willoughby College merged with it). At this time Dr. Smith was honored with two appointments. He was appointed a member of the Board of Trustees by Mr. Lynn Starling, the benefactor of the Starling Medical College; he was also made Professor of Materia Medica and Therapeutics, in addition to his previous appointment as chairman of the section on Medical Jurisprudence and Insanity. He was appointed the second dean of the Starling Medical College in 1849 and maintained this position until 1858. He resigned at this time only to return for a second term as dean from 1861 to 1865. Starling Medical College eventually became Ohio State University College of Medicine(5, 6, 7).

The Ohio Medical and Surgical Journal, Vol. 1, 1849, contained the following notice about Starling Medical College—

> the annual course of lectures will commence on the first Wednesday in November—next (November 7, 1849) and will continue sixteen weeks. The preliminary courses will commence on the first Wednesday in October during which month there will be three lectures daily. In October, the follow-

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ing subjects will be taught: Minor Surgery, Dr. Howard; Insanity, Dr. Smith; Poisons (illustrated by experiments on lower animals), Dr. Carter; Microscopic Anatomy, Dr. Gay; Physical Diagnosis, Dr. Butterfield. Signed, S. M. Smith, Dean of the Faculty.

In 1850, it appears, there were no longer any distinct chairs of Insanity in any medical college in the United States, according to Dr. Edward Mead, who was editor of the American Psychological Journal(8). Dr. Mead stated in its last issue, which was published in November, 1853, "Dr. S. M. Smith, of the Starling Medical College, having sometime since been transferred to the Chair of Theory Practice, we believe there is now no distinct Professor of Insanity. This is a serious defect in the course of instruction provided by medical colleges." In 1859, Governor Salmon P. Chase appointed Dr. Smith Surgeon-General of the State of Ohio, which post he held under Governors Dennison and Tod. He was also appointed by Governor Chase as a trustee in the Central Ohio Lunatic Asylum, in which capacity he served for 18 years. Dr. Smith was one of the original anti-slavery men in the State of Ohio. He was one of the first in this part of the country to join the Republican Party. He was familiar with the Bible, and was seldom at a loss for a quotation therefrom. He was the first doctor in Columbus to administer chloroform to a woman in labor. In 1870, 4 years before his death, the transactions of the Ohio Medical Society show that he was still interested in psychiatry as he was appointed to a special committee to examine the Plea of Insanity in Cases of Homicide.

During the Civil War he was a member of the Board of Examiners of Army Surgeons at Camp Chase, located on West Broad Street in Columbus, Ohio. After the war, he was appointed a member of the Board of Examiners of Pensions. Doctor Smith was the twenty-fifth president of the Ohio State Medical Society (Association), holding office in 1869-70. He presided at the twenty-fifth, or silver anniversary meeting of the society which met in Cleveland on June 14-16, 1870.

Dr. Smith has been overlooked by those writing on the history of psychiatry in America because he was not a man to publish scientific works. Although he had considerable fame locally, he was never apparently too famous on the national scene. There is a statue to his memory standing on the grounds of the City Health and Safety Center Building in Columbus, Ohio. This statue is approximately 77 years old and once stood in the town square in Columbus, Ohio.

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CORRESPONDENCE

CHRONIC PSYCHOSIS FOLLOWING EPILEPSY

Editor, THE AMERICAN JOURNAL OF PSYCHIATRY:

SIR: I would like to comment on the article by Dr. Bartlet on "Chronic Psychosis Following Epilepsy" in the October, 1957 issue of The American Journal of Psychiatry.

The problem of schizophrenia occurring in the epileptic patient has long been of interest to me. It is difficult, if not oftimes impossible, to differentiate schizophrenia in the non-epileptic from schizophrenia developing in the epileptic patient. I have observed religious preoccupations with Messianic delusions in the epileptic patient with schizophrenia to be more frequent than in Dr. Bartlet's series of cases and also that impulsive actions, either homicidal attempts or destructiveness of property, occur more often in these people than in the non-epileptic schizophrenics.

Dr. Bartlet's observations of the rarity of depressive psychoses in epileptics was not corroborated by a recent study of admissions to the Psychiatric Division of the Kings County Hospital Center, Brooklyn, New York. During the first 8½ months of 1957 there were 15 known epileptic patients who developed a functional psychosis after having suffered from epilepsy for at least 5 years. Of the 15 patients, 7 were moderately to markedly depressed (3 of these being diagnosed as suffering from an involutional psychotic reaction and 1 from a psychotic depressive reaction). There were 2 markedly depressed schizophrenic patients who had attempted suicide.

Consideration must be given to diagnostic groupings between any two hospital populations. Dr. Bartlet's figures, derived from the Bethlem Royal and Maudsley Hospitals, London, England, for the 1949-53 period, contrast sharply with the January 1-September 15, 1957, admissions to the Psychiatric Division of the Kings County Hospital Center. The English hospitals had 167 schizophrenic patients and 121 manic-depressive reaction patients admitted. During the above mentioned 8½ month period Kings County Hospital Center had admitted 2,118 patients with schizophrenic reactions and only 33 patients with manic-depressive reactions. The hospital records for the past 5 years show about the same proportion of schizophrenic and manic-depressive patients. This striking difference is only partly accounted for by hospital selectivity of patients, genetics, and other factors. The utilization of more subtle dynamic and clinical clues by the psychiatrists may be an important factor in the contrasting statistics between both hospitals.

IRVING J. FARBER, M. D.,
Forest Hills, New York.

REPLY TO THE FOREGOING

Editor, THE AMERICAN JOURNAL OF PSYCHIATRY:

SIR: Thank you for the opportunity to comment on Dr. Farber's letter.

Most of the discrepancies between Dr. Farber's experience and mine are due in my opinion to the difference in the type of patient referred to the Bethlem Royal and Maudsley Hospitals on the one hand and the Kings County Hospital Centre on the other. The former hospitals admit patients only considered to have a relatively good prognosis, while I imagine the latter Centre copes with the general run of psychiatric illness both acute and chronic. The utilization of more subtle dynamic and clinical clues by one of the groups of psychiatrists concerned may be a factor, but if an additional factor is required I would consider that the use of different diagnostic criteria was more important.

Dr. Farber's reference to depression in his group of patients is in no way contradictory to my findings unless he excludes all those

that could be diagnosed as suffering from schizophrenia by my criteria and all patients who have not had delusions for a period of at least one year. Nevertheless, I find it interesting that he found such a high percentage of depressed patients in his group, especially as they came from a psychiatric population in which affective disorder occurred so infrequently.

J. E. A. BARTLET, M. D.,
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Basingstoke, England.

SIMULATED RETARDATION

Editor, THE AMERICAN JOURNAL OF PSYCHIATRY:

SIR: Emotional deprivation in early childhood is a well known cause of simulated retardation. At the present time the idea of functional retardation (as shown by psychological testing) with better or normal inherent capacities is expressed by such terms as "pseudo-retardation," "apparent feeblemindedness," or "mental deficiency" or other similar combinations.

I suggest that these cases be called *"dysmentia"* to indicate disturbance in mental functioning as it applies to the intellectual sphere, and which may be temporary.

This would give a more hopeful attitude towards such patients and *ipso facto* call for further follow-up and/or testing.

IRWIN J. KLEIN, M. D.,
Brooklyn, New York.

PSYCHICAL RESEARCH

Editor, THE AMERICAN JOURNAL OF PSYCHIATRY:

SIR: Please permit me a brief protest about the review of Dr. Thomas Szasz of *Psychical Research* by Dr. Raynor C. Johnson. This appeared in the November issue of The American Journal of Psychiatry.

Dr. Szasz's review seemed to reproach Dr. Johnson with including "no new data" beyond that already available. *Psychical Research* was written and presented as a brief condensation and summary of data published elsewhere. No popular introduction to physics or biology contains new data and none are expected to. Why should this be required of a similar book on psychical research?

But I am chiefly concerned with Dr. Szasz's sweeping condemnation not merely of Dr. Johnson's little introduction to psychical research, but of the entire subject itself. Dr. Szasz writes as if none of the facts adduced by psychical research deserve any interest for themselves as facts to be explained and understood. He assumes that psychical research is a subject for psychopathology to study and does not consider that it might contribute to psychopathology and psychiatry. In this position Dr. Szasz is not alone but neither are psychical researchers any more. For a great many scientists eminent in other fields, as Dr. Johnson is in physics, have examined the data of psychical research and have become impressed not only with the actuality of many of the reported observations but also with the importance of their further study. The interest of eminent scientists itself provides no clue to the veridicality of any evidence. But it can, I think, make unreasonable the epithets such as "paranoid pseudoscience" applied to psychical research by Dr. Szasz. In this respect I think Dr. Szasz's review bad criticism. For it constitutes a kind of censorship by presenting a one-sided account not merely of a single book but of a whole subject. This is, to vary a well-worn phrase, throwing out not merely the baby and bathwater but the mother also from whom might be born other babies.

In its brief history psychical research has suffered considerably from charlatans and too credulous investigators who were easily persuaded that they have seen what they expected and wanted to see. But it has suffered hardly less from uninformed and too incredulous critics whose prejudices have closed their minds to any new conceptualizations of our universe.

Between these fanatical extremes serious psychical researchers pursue a slow and slowly rewarding course of investigation. These few lines can add nothing to the merits of their work, but will, I hope, remind the editors of The American Journal of Psychiatry that reviews such as Dr. Szasz's run against the JOURNAL's tradition of fair criticism.

IAN STEVENSON, M. D.,
Univ. of Virginia School
of Medicine.

REPLY TO THE FOREGOING

Editor, THE AMERICAN JOURNAL OF PSYCHIATRY:

SIR: Many thanks for inviting me to reply to Dr. Stevenson's criticism of my review of Dr. Johnson's *Psychical Research.* As I see it, Dr. Stevenson objects to my review on two distinct grounds. First, he appears to hold that psychical research in general, and this book in particular, has more scientific merit than I said it had. Secondly, he states that my review was unfair. I would like to deal with these two issues separately.

In regard to the scientific aspects of this matter, I had frankly stated my position toward this subject at the beginning of my review. I then cited illustrative passages from the book and concluded with some brief *logical arguments* concerning the problem at hand. I have set forth in greater detail elsewhere what I thought was "wrong" with most of the work in parapsychology ("A Critical Analysis of the Fundamental Concepts of Psychical Research," Psychiat. Quart., 31: 96-108, Jan., 1957). Dr. Stevenson cites no evidence—factual or theoretical—in support of his own position. He simply advocates adhering to the golden mean, and proposes to steer a middle course between what he calls "charlatans" on the one end, and "uninformed critics" on the other. I am reminded in this connection of Edward Glover's witty comments about eclecticism which, he said, "is generally regarded as a form of objectivity, reflecting credit on those who cultivate it. This is a view which the casual reader, always inclined to see fair play and confusing eclecticism with impartiality, feels strongly disposed to support. Believing that there must be at least two sides to any question, he finds it hard to conceive that one side may rest on total error" (E. Glover: *Freud or Jung?,* New York: Meridian Books, 1956, p. 187).

Concerning Dr. Stevenson's second charge, namely that of unfairness on my part, I would like to say this. What constitutes "fairness" and "unfairness" in the evaluation of scientific works in scientific journals—much like the rules governing all forms of social behavior—is subject to considerable variation from time to time, and from person to person. His criticism, on this ground, may therefore simply express a difference of opinion, or personal style, between us. I wished to be "fair" and I thought I was. No doubt, however, I interpreted this word, in my own way. Thus, I thought I merely "criticized" Dr. Johnson's book, but Dr. Stevenson states I "condemned" it. Similarly, I did not apply the epithet of "paranoid pseudoscience" to psychical research—as Dr. Stevenson states—but wrote as follows: "Human activities having some pertinence to this problem (*i.e.*, the problem of object loss and our attempts to solve or master it) thus encompass, among others, science, religion, fiction and paranoid pseudoscience. This book, and many others dealing with "psychical research," may be regarded, therefore, as posing an interesting—and perhaps for some people, an important—challenge in distinguishing between good science, bad science, science fiction and paranoid system building."

Clearly, while I brought up the notion of "paranoid pseudoscience" in connection with the subject at hand, I did not apply it *specifically* to psychical research. If the shoe does not fit, why put it on? Personally, I am prepared to entertain that any particular work may fit into one of these categories whether it is propounded in cancer research, psychoanalysis, parapsychology, or any other area of inquiry. And I meant to imply this much in my review. In science, nothing is safe from doubt. And I merely said that I doubted almost everything in psychical research. If to say directly what one thinks,

and to support one's position by means of logical arguments, is unfair—so be it.

Still, how a review such as mine can constitute a "kind of censorship," I cannot see. Indeed, since Dr. Stevenson's criticism of my comments is essentially an *ethical* one, I would like to conclude on a frankly ethical note. Surely, the ethics of proper scientific criticism have not been defined for all time to come. Personally, I try to hew close to the lines of what is perhaps a romantic scientific ethic, according to which a good critic is one who states clearly what he thinks of a piece of work and gives the reasons for his views. If my work were treated in this way, I would consider it "fair" criticism.

I appreciate your courtesy for allowing me to reply at such length.

THOMAS S. SZASZ, M. D.,
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Syracuse, New York.

COMMENT

A REALISTIC APPROACH TO TRAINING RESEARCH PERSONNEL

Scarcity of high grade professional personnel exists everywhere in psychiatry, but in no area is it more apparent or problematical than in psychiatric research. Interest and devotion to clinical psychiatry is abundant and the rewards quite equivalent. But research workers, like educators, still trudge the path of the poor cousin through fields of plenty. Questionable financial security is not the only responsible road block however in advancing recruitment of the research-minded. There are a number of policy changes, positive in type, which would improve present situations.

One clinical training center, 25 years ago, took special interest in spotting students in the medical schools who had a potential interest in psychiatry, and who appeared to be of teaching calibre. Reasonably adequate stipends were provided during the training period, emphasis was placed on inclusion of teaching experience, paths were kept open for further extension of teaching opportunities. Due to this selection policy and program consistency, this one training center played a major part in the training of an amazing percentage of the present professors of psychiatry in the United States, and hospital or department heads of equivalent rank.

A similarly effective program is possible in psychiatric research, either for the basic sciences or clinical psychiatry, and a program of unification of the two phases of research is likewise indicated.

More and better psychiatry is now taught in our medical schools. Students are showing a consistent and healthy interest. To take advantage of this, plans should be organized now for a new type of research training program in psychiatry. Deans and professors of medical schools, and other individuals of similar interests should be informed that selcted students should be spotted who show capacity for research. A planned 5-year program to follow the internship should be set up, approximately one half-time training in basic science laboratories, and the other half-time in basic hospital clinical psychiatry. As the trainee developed, and displayed his best native capacity, the shift toward basic science research or its clinical application would naturally work itself out.

Many good things would result, among them an especially valuable one, that the Board-qualified man of the future would be equally as well trained in basic science and clinical research as in clinical practice. Undoubtedly many would remain in research or teaching, the goal hoped for in this proposal.

Some training centers or certain few trainees may by accident have followed this plan. But their scarcity is apparent.

To do this requires some change in thinking in many places. The American Board of Psychiatry and Neurology must give thoughtful consideration to allowing a generous high priority of training to such a program—lest its length be prolonged too extensively in acquiring clinical training credit. A liberal stipend provided from the first year to furnish personal and family comfort, proportionate to the economy of the period of training, not only should be high in relation to other competing programs, but also high enough to actually attract interest. Dozens of the nation's largest big name industries send personnel agents to visit senior class members of all colleges, offer them beginning salaries from $500 to $600 a month, and expect only a few leaders and profitable staff members to emerge from such a recruitment program. Medicine should be realistic and compete in the same manner, in its own area, which means with private practice. A beginning stipend for a trainee entering this program should be no less than $5,000 per year, to be followed each year by a substantial increase, naturally aiming in 3 to 5 years at an income level not too far below the average net income of private practice.

This type of plan would work in medicine, surgery—any of the specialities. But it is vital to the future of research and a broader training in psychiatry.

L. H. S.

THERAPEUTIC COMMUNITY FOR DELINQUENTS?

Others studying delinquency may be interested in recommendations evolved by a Washington, D. C. project. This "Maximum Benefits Project" is one of several activities sponsored by Washington's Youth Council, a group of civic leaders appointed by the District of Columbia's Commissioners to do a city-wide coordinated study of delinquency. Supported financially by the private Meyer Foundation, the Maximum Benefits Project in 1954 began its study of efforts to prevent delinquency by operations centered in elementary public schools. Psychiatrists and social workers on this project have come to agree with those who emphasize the need for a new or at least a basically reorganized method of approaching delinquency.

Why add another proposal to the welter of already existing ones? The welter of piecemeal plans in itself gives the clue; there is a need for an organization that will provide a matrix in which some of the plans can be carried out in a more effective way. The study of delinquency (and other social ills also) needs what the free association technique has been for psychoneuroses and other psychological matters: namely, a methodological tool that will open the way to improved understanding and treatment.

In general, our proposal calls for further mobilization of the resources of both the community and the delinquents' families. Details will be elaborated in later publications, but some cardinal points are intemized below in the hope of inviting comments:

1. Comprehensive coordination of community resources under one centralized administration authorized to deal with all aspects of delinquency.

2. Identification and central registration of families that require community assistance. Registration should preferably be at a national as well as local levels.

3. Public enlightenment about the "hard core" families which produce most delinquents and about the need for a realistic long-term program to deal with these families.

4. Efforts to prevent delinquency beginning with early family life, *i.e.* even earlier than the elementary school level studied by our project.

5. In starting the preventive program early, utilization of family contacts with all other community agencies as well as the school.

6. Long term work with families, placing more emphasis on the total family and its progress through the years and not just on the individual child and the immediate problem.

7. Greater attention to the idea that a disservice is done when the community attempts to meet a family's dependency needs without expecting the family to make some progress in mobilizing its own resources.

8. Working out effective procedures for the community to make clear its expectations of families receiving community assistance and to help them meet such expectations.

9. Recognition of the social incompetence of those families who, even with the help of such a program are unable to provide themselves with adequate home life.

10. Establishment of a sub-community within the community administered by trained personnel authorized to develop a "therapeutic community" designed for the needs of such incompetent families.

Of course, a number of the above 10 points have been suggested before. The Project proposal seeks to fit them into an organized workable plan of action and, in addition, suggests a new method of dealing with those families who fail to respond to the sequence of actions outlined in points 1 to 8. This new method is the therapeutic sub-community which, for example, could be established in housing projects erected in slum clearance programs of some cities.

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THE AMERICAN BOARD OF PSYCHIATRY AND NEUROLOGY, INC.

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* Denotes Supplementary Certification.

OPINION

The greatest number of minds seem utterly incapable of fixing on any conclusion, except from the pressure of custom and authority: opposed to these there is another class less numerous but pretty formidable, who in all their opinions are equally under the influence of novelty and restless variety. The prejudices of the one are counterbalanced by the paradoxes of the other; and folly, "putting in one scale the weight of ignorance, in the other that of pride," might be said to "smile delighted with the eternal poise."

—William Hazlitt

HANDLING THE MACHINE

A great problem that man has never faced squarely hangs like the sword of Damocles over his head. The question is, does man to-day possess sufficient soundness of mind to exercise intelligent control over the complicated civilization he has created? Upon this intelligent control depends the happiness of the individual, the first settlement of the problems of labor and capital, the peace of the world, the fate of democracy, and the destiny of the race. . . .

The majority of people do not even know that the final test of the sound mind implies sane conduct, not merely intelligent thinking.

—Stewart Paton
(Signs of Sanity, 1922)

NEWS AND NOTES

Gracie Square Hospital.—A 232-bed, fully air-conditioned psychiatric hospital is now under construction at 420 East 76th Street, New York City, with completion scheduled for October 1, 1958. It is designed as an "open ward" hospital for intensive treatment of adults suffering from all types of acute psychiatric disorders, including those with complicating medical or surgical problems.

Plans are being made for residency training, nurses' training, and research programs. Leonard Cammer, M. D., will be director, and Lothar Kalinowsky, M. D. will be chief consultant. Address inquiries to Dr. Leonard Cammer, 132 East 72nd Street, New York, N. Y.

The Adolf Meyer Awards.—The Adolf Meyer Awards Committee of the Association for Improvement of Mental Health, Inc., is inviting nominations for the 1958 awards, which will be announced during Mental Health Week, in May. These awards are given annually to individuals and/or organizations who have made meritorious contributions to the professional care and treatment of the mentally ill, both in and outside of hospitals.

Nominations for this award should be sent to Dr. Milton M. Berger, Chairman, Advisory Committee, A.I.M.H., 50 East 72nd St., New York 21, N. Y., before April 1, 1958.

American Society of Clinical Hypnosis.—Milton H. Erickson, M. D., Phoenix, Ariz., has been elected president of the recently organized American Society of Clinical Hypnosis. Dr. Erickson has also been appointed editor of the *American Journal of Clinical Hypnosis,* to be published by the Society. Dr. Erickson was also recently elected to the executive council of the Academy of Psychosomatic Medicine.

Dr. Roberts Heads Verdun Protestant Mental Hospital, P. Q.—Dr. Charles A. Roberts, principal medical officer in the Mental Health Division of the Department of National Health and Welfare, Ottawa, Canada, has resigned. He has been appointed medical superintendent, Verdun Protestant Mental Hospital, Verdun, Que., and assumed his new duties on December 15, 1957. Dr. Roberts joined the Mental Health Division in the federal government department in August, 1951, became chief shortly afterwards, and subsequently was promoted to principal medical officer. During his tenure of office there, he was concerned with the administration of the federal Mental Health Grant of about $7,000,000 and his efforts and advice were widely appreciated by the Directors of Mental Health of the provinces and by others in the universities and voluntary societies with whom his work brought him into contact. He was also active in the field of health insurance studies, which after two decades of governmental planning are now about to bear fruit. Among his new duties will be the direction of a large mental hospital with a very active research programme and teaching at McGill University's Department of Psychiatry.

American Board of Psychiatry and Neurology, Inc.—Two examinations will be given in 1958. The first will be held in San Francisco, Cal. on March 17 and 18, 1958, and the second on December 15 and 16, 1958, in New York, N. Y.

The Board also announces termination of training credit for military service in the Korean emergency. Training credit for full-time psychiatric and/or neurologic assignment in unapproved military programs or services between the dates of January 1, 1950, and January 1, 1954, will be terminated on January 1, 1959.

THE COLLEGIUM INTERNATIONALE NEURO-PSYCHOPHARMACOLOGICUM.—The C.I.N.P. will meet in Rome from September 9-12, 1958, under the direction of Prof. Ernst Rothlin. The Congress President will be Prof. Emilio Trabucchi.

The program will include symposia on the following subjects: Methods and Analysis of Drug-Induced Abnormal Mental States in Man; Comparison of Abnormal Behavioral States Induced by Psychotropic Drugs in Animals and Man; Comparison of Drug-Induced with Endogenous Psychoses in Man. Plenary sessions will be devoted to: The Impact of Psychotropic Drugs on the Structure, Function and Future of Psychiatric Services; (a) in the hospitals, and (b) in extramural clinics and private practice. The fourth day will be given over to the presentation of original papers.

For further information, write to Herman C. B. Denber, M. D., secretary, Manhattan State Hospital, Ward's Island, New York 35, N. Y.

DEATH OF DR. GEORGE PRATT.—Dr. George Kenneth Pratt, psychiatrist on the neuropsychiatric staff of Bridgeport Hospital, Conn., died Dec. 12, 1957, at the age of 66.

Born in Detroit, Dr. Pratt received his medical degree from the Detroit College of Medicine and Surgery and did graduate study at the State Psychiatric Hospital, University of Michigan. Among the numerous positions which Dr. Pratt held were those of medical director, Mental Hygiene Commission, New York State Charities Aid Association; assistant clinical professor of psychiatry and mental hygiene at the School of Medicine, Yale University; psychiatric director for the Stamford Child Guidance Service and the Bridgeport Mental Hygiene Clinic.

Dr. Pratt was a diplomate of the American Board of Psychiatry and Neurology, and a member of The American Psychiatric Association. He was the author of several books including *Your Mind and You, Why Men Fail,* and *Soldier to Civilian.*

THE NATIONAL ASSOCIATION OF RECREATIONAL THERAPISTS.—The 6th annual Conference and Institute of the Association will be held March 16-20, 1958, in Topeka, Kan.

This promises to be an outstanding opportunity for "Recreators" to get together in an atmosphere of constructive thinking and gratifying achievement. Several leaders in the Midwest and other areas have consented to take part in the general program and Institute. Make plans now to attend this Conference that will involve all areas of Recreation.

For further information write to Ira J. Hutchinson, General Conference Chairman, Topeka State Hospital, Topeka, Kan.

PROTECTION AGAINST POLIO.—Four outstanding events are listed in a review of polio in 1957 by Basil O'Connor, president of the National Foundation for Infantile Paralysis. They are: 1. The massive vaccination promotion of the spring and summer of 1957; 2. The consequent drop of paralytic polio; 3. The expanding research projects of the March of Dimes organization; 4. The undertaking by the National Foundation of a program, called "Operational Comeback," to bring benefits of modern rehabilitative techniques to many thousands of polio patients who were stricken by the disease in years past and still need help.

Only 3 out of 5 Americans in the susceptible age group under 40 have had one or more injections of Salk vaccine, according to revised Public Health Service estimates as of Dec. 1, 1957. This leaves 2 out of 5 who are just as vulnerable today to polio paralysis as if there had never been Salk vaccine. Unless most of the 45,000,000 of unvaccinated citizens under 40 get their Salk shots before the next polio season, there is no assurance that we may not again have epidemics and tragic crippling in 1958.

BASIC PSYCHIATRIC NURSING CONFERENCES.—The National League for Nursing, Inc. announces that conferences for faculty and administrators of basic baccalaureate degree programs in nursing will be held in 5 cities to study the relationship of psychiatric nursing content to other areas of the nursing curriculum.

Sponsored by the NLN Mental Health and Psychiatric Nursing Advisory Service, under a grant from the National Institute of Mental Health, these conferences will be held as follows: March 18-20, Atlantic City; April 14-16, Boston; April 18-20, Cleveland; May 7-9, San Francisco; April 24-26, Washington, D. C.

For further information address The National League for Nursing, Inc., 2 Park Avenue, New York 16, N. Y.

Grants totalling more than $400,000 have been received by the National League for Nursing, New York, for the support of programs designed to increase the number of students in both basic and graduate nursing education, and to improve nursing care of the mentally ill. Currently more than 100,000 aides are giving much of the direct nursing care to the 700,000 patients in mental hospitals, the NLN reports.

Archives of Criminal Psychodynamics Freud Issue.—Volume 2, No 2 (Spring 1957) of this Journal, just received, is a special issue commemorating the Freud centenary. In addition to the usual space for regular articles there are 100 pages devoted to commemorative articles, and 12 further pages containing abstracts of contributions related to the Freud centenary mainly in Spanish publications. There is also a group photograph of Freud with his wife and daughter on their arrival in London.

Recreation for the Elderly.—The Adult Recreation Council of the New York State Department of Education has issued a pamphlet entitled *Recreation for the Elderly* for the use of those interested in the leisure-time problems of the aged. The pamphlet gives suggestions to leaders in this field on steps to take in expanding existing programs and setting up municipal programs of recreation within the terms of legislation passed in 1956, which authorizes state aid to cities in furnishing recreational programs for senior citizens.

Copies of the pamphlet are available from the Adult Recreation Council, 23 South Pearl Street, Albany, N. Y.

Human Adaptation to Disaster.—The 1957 Summer issue (Vol. 16, No. 2) of *Human Organization,* a quarterly journal published by The Society for Applied Anthropology, is a special issue devoted to human adaptation to disaster. The topics covered include The English Flood of 1953; Disasters Compared in Six American Communities; Typhoons on Yap; Some Functions of Communication in Crisis Behavior; Problems of Perception in Extreme Situations; together with an annotated bibliography on disaster research.

Training in Group Relations.—The National Training Laboratories of the Division of Adult Education Service of the National Education Association, Washington, D. C., will conduct its 12th annual Summer National Training Laboratory in Group Development at Gould Academy in Bethel, Maine. The sessions will consist of two 3-week periods, June 15-July 4, and July 13-August 1, 1958, with 150 persons admitted to each session.

The purposes of this training program are to develop more effective human relations, knowledge, insights and research in professional and volunteer leaders; to study problems of intergroup relations and organizational conflict, and to plan for effective work in the community.

For further information write to: Mrs. Aieleen Waldie, NTL, 1201 16th St. N.W., Washington 6, D. C.

World Medical Periodicals.—The 2nd edition of *World Medical Periodicals,* published by The World Medical Association, October 1, 1957, is available at 30 shillings (Br) or $6.00 (USA) per copy. This book of 340 pages contains a list of nearly 5,000 titles of medical periodicals with 4 special appendixes. The text is in English, French, German and Spanish.

Orders should be addressed to: The Editor, *British Medical Journal,* Tavistock Square, London W.C. 1, England.

Re: Malthus.—Approximately 4,318,000 babies were born in the United States during 1957. This would be about 98,000

ahead of last year's record, and probably set a new record for the 7th straight year, as reported by the U.S. Public Health Service.

Recent yearly increases in births are the result not only of an increase in the number of marriages but of a trend toward larger families, the Service said.

Dr. Margaret Smyth Dies.—On December 30, 1957, occurred the death of Dr. Margaret Hamilton Smyth in Palo Alto, Cal., age 84.

At the Golden Gate International Exposition of 1940 in San Francisco, Dr. Smyth was voted California's most distinguished woman in medicine. She obtained her medical degree from Cooper Medical College, which later became the medical school of Stanford University. She served as director of Stockton State Hospital and was a past-president of the San Joaquin County Medical Society, which gave her a special award for her outstanding service. She also received an honorary Doctor of Science degree from the College of the Pacific.

It will be remembered that Dr. Smyth contributed a comprehensive review of psychiatric facilities in California in connection with the first meeting of The American Psychiatric Association on the Pacific coast in 1938. This report appeared in the March 1938 issue of the Journal.

Indiana Mental Health Services.—Dr. John W. Southworth, superintendent, Logansport State Hospital, has been appointed deputy commissioner, Indiana Division of Mental Health, effective January 1, 1958.

Dr. Ernest J. Fogel, chief of neurology and psychiatry at the VA Hospital, Indianapolis, Ind., and associate professor of psychiatry at Indiana University will become the 11th superintendent at Logansport on March 1, 1958. During the interim January 1 to March 1, 1958, Dr. Frank D. Hogle, assistant superintendent, will serve as acting superintendent at Logansport State Hospital.

National Association for Retarded Children, Inc.—The 9th annual convention of the National Association for Retarded Children will be held in Philadelphia, October 8 to 11, 1958.

The meeting will consist of exhibits, general sessions and workshops on all phases of mental retardation.

For additional information write: NARC Convention, 99 University Place, New York 3, N. Y.

American Orthopsychiatric Association.—The 36th annual meeting of the American Orthopsychiatric Association will take place in New York City, March 6-9, 1958. The association is a national professional organization in the field of the behavioral sciences, bringing together the key disciplines involved in the team approach to prevention and treatment of behavior problems and related training and research.

Some 60 scientific papers will be delivered at the meeting. Workshop sessions will include such topics as: methodologies for studying healthy behavior; learning disturbances and retardation; use of newer drugs in child psychiatry; factors associated with mental disorders among the aged; and relationship between the problem family and juvenile delinquency.

For further information write: Dr. Marion F. Langer, executive secretary, American Orthopsychiatric Association, 1790 Broadway, New York 19, N. Y.

Death of Dr. Young.—Dr. G. Alexander Young, former head of the department of neuro-psychiatry at Creighton University and the University of Nebraska, died Nov. 4, 1957, at the age of 81.

Dr. Young, a graduate of the Chicago Homeopathic College, became superintendent of Norfolk State Hospital in 1908. In 1909 he resumed studies in London and Zurich, becoming a student of Dr. Carl Jung. The following year he entered private practice in Omaha.

For many years he headed the staff of County Hospital, was head of the Douglas County Board of Mental Health, and consultant in psychiatry for the Union Pacific Railroad.

Dr. Young is credited with introducing the use of insulin to the Midwest in the treatment of mental illness.

BOOK REVIEWS

The Facts of Mental Health and Illness. By *K. R. Stallworthy.* (Christchurch, New Zealand: N. M. Peryer Ltd., 1956, pp. 215. 18/6.)

This book is written for the layman interested in furthering his knowledge about mental health and illness. In substance, it stems from a series of some 20 lectures delivered before lay audiences of the Regional Council of Adult Education in Auckland. Suggestions for their publication came from those having attended these lectures. The book contains no new or startling ideas about mental health and illness. It contains only that which is generally acceptable in professional circles.

The author, Senior Medical Officer of the Auckland Mental Hospital, presents his material lucidly with few technical terms, and when the latter are used, they are clearly defined. He implies that an individual has positive mental health when he gets from and gives to life all that is to be given, in accordance with his individual talents, capacities and circumstances; when he has the knack for accepting the unalterable as that which cannot be altered, and, succeeds in altering those things that can and should be altered in oneself or in things about them. He implies also that positive mental health is the ability to live happily and easily with others, mellowed by understanding and sympathy and unembittered by things deserving no bitterness; and with this a willingness to give help when possible, and to seek help when needed. Thus the spectrum of many traditional virtues are an essential part of positive mental health, and their lack is evidence of unhealthfulness that often lies at the root of troubles which plague the mentally ill.

A brief summary is appended to the last chapter and with it a brief admonition: "Psychology and psychiatry are of such real and potential importance to every individual that the intelligent layman should take the trouble to find out a little about them, but he will do well to try to distinguish between facts established by observation and experience, and the theories which, however interesting and ingenious, are best taken with a grain of salt until proved beyond argument."

The book admirably fulfills its aims and purposes, namely as a reference for intelligent laymen who desire more knowledge about mental health and illness

W. L. T.

The Early Detection and Prevention of Disease. Edited by *John P. Hubbard, M. D.* (New York: Blakiston Division, McGraw-Hill Book Co., 1957. $7.50.)

Although the title of this book does not show that it is of special interest to psychiatrists, a review of the table of contents would definitely indicate that there is much that would be worthy of their attention. In Part 2: Preventive Medicine and the Cardiovascular System, there is an article by Dr. Leon J. Saul, titled, "Psychogenic Factors Related to Hypertension," and another by Dr. Harry F. Zinsser, Jr., titled, "Prevention of Cardiac Neuroses." Part 5 is devoted to: The Norms of Mental Health and Early Detection of Deviations from the Norms, in which Dr. Milton J. E. Senn discusses "The Child," Dr. Benjamin H. Balser, "The Adolescent," Dr. Kenneth E. Appel, "The Adult Male," and Dr. O. Spurgeon English, "The Adult Female." In the last section there is a discussion of the "Practical Application of Preventive Medicine in the Armed Services."

Dr. Senn, in opening his discussion, states: "The norms of behavior and mental health are not an easy topic to discuss. The subject is abstract and less tangible than a discussion of diseases or symptoms. Although disease may often be difficult to diagnose, nevertheless it is easier to determine what is wrong physically than psychologically or socially." This book has made a very encouraging start towards this end. It contains both chapter bibliographies and an index.

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The Mentally Retarded Patient. By *Harold Michal-Smith.* (Philadelphia: J. B. Lippincott Co., 1956. $4.00.)

This book is another of several published recently in response to an awakened interest in the problems of the mentally retarded and their parents. In the foreword the author states that the book was written by a psychologist who had been working with physicians in a clinic for the mentally retarded and that it was intended particularly for physicians.

Such a publication is timely and very much needed. The medical profession as a class has been guilty of not taking sufficient interest in the mentally retarded child. Its members generally have had little understanding of and sympathy for the parents and their emotional problems engendered by the retarded offspring.

The realization and acceptance that their child is definitely retarded is extremely difficult for many parents. Often this tragic situation produces an emotional state bordering on panic in which guilt, inferiority, punishment and frustration are very serious emotional factors. These parents are in dire need of a sympathetic understanding of their situation and of professional advice concerning both the best procedures in the training of the child and a solution of their own emotional difficulties. There should never be the rebuff which so many parents have experienced with the blunt and cruel advice that as the condition is incurable and hopeless the child should be placed immediately in an institution. Some have gone still further and advised the parents

to forget the child as soon as placement was made.

All too frequently both psychiatrists and pediatricians have been definitely unwilling to spend any time treating an obviously retarded child except possibly when called as physicians to treat an acute medical condition.

As mental retardation is, as far as we know, an abnormality of biologic mental development or due to a pathologic mental condition it is definitely a psychiatric problem. It is extremely regrettable that psychiatrists have taken so little interest in these children. Pediatricians are showing much more interest and are helping both the children and the parents. The latter perhaps in many instances would be better understood and helped by a psychiatrist.

The presence of the word "patient" in the title denotes that the substance of the book is directed toward methods of treatment particularly by physicians. It is equally instructive to members of the other professions who are in any way assisting with the education, training and placement in employment of mentally retarded persons.

The various chapters of the book are well organized and the author presents in a very understandable manner details of procedures necessary in assisting the retarded individual. The first chapter—"The Role of the Physician"—describes situations when a physician is called upon for advice in the management and training of the retarded. The author gives excellent advice in detail which should be very helpful to any counselors as well as physicians.

The second chapter is mainly concerned with the emotional problems found in children with brain impairment. A good psychological presentation is made. Chapter five is entirely psychological and describes measuring techniques and their interpretation.

In Chapter 3 Dr. Lawrence Slobody presents a classification of mental retardation. Several such have been formulated and this arrangement seems to be adequate and entirely workable.

In the chapter on "The Psychological Situation," the author rather belittles the occurrences of the familial type of mental retardation. It is very true that fewer cases of retardation are now diagnosed as purely familial, but the condition does exist and is probably encountered more often in institutions than in clinics.

In the chapter "Attitudes Toward Prevention and Etiology," the author states, "We do not know who should and who should *not* have children." On the whole this is very true. There are, however, a few types of retardation which can be positively diagnosed as genetic in origin. Rarely a dominant gene but fairly frequently the presence of recessive genes in the parents is the etiological factor. Physicians who did not diagnose this type of retardation and consequently did not know the implications have told parents that the child's condition was simply an accident of development and to have more children. The tragedy of having another or several retarded children which could have been prevented by proper advice should be impressed on physicians.

In the earlier chapters in describing patients much mention is made of the I.Q. and very little of the M.A. The use of I.Q. is perfectly proper, but in a book to be read by those not using I.Q.'s daily the use of M.A. is often much more realistic and informative. This is very evident in the chapter "Vocational Prognosis" where predictions are most practical and based on the M.A. degree of mental development.

The chapter on education goes into excellent detail and will be very helpful not only to teachers and other professional workers but to parents. This is also true of the chapter on "Vocational Prognosis."

In the last chapter, "Looking Forward," the statement is made that in institutions there are no funds for research. That funds are decidedly inadequate is true but in several states research is supported by specific appropriations. Research has been conducted for many years with very little or no support. In the future, research projects will undoubtedly increase in number and importance, both in institutions and in the communities.

Following the last chapter is a very good bibliography for professional workers and also as an appendix a very complete list of state and private institutions in the United States caring for the mentally retarded child.

On the whole this book is a valuable addition to the literature concerning the education, training and placement in employment of the mentally retarded. It should be read by all who are in any way interested in their welfare. Not only will physicians find it instructive, but parents, teachers, psychologists, social workers and counselors will gain knowledge which will help them in their attempts at solving the many and varied problems presented by those of retarded mental development.

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RÖNTGENDIAGNOSTISCHE PROBLEME BEI INTRA-KRANIELLEN GESCHWÜLSTEN and ELEKTROENCEPHALOGRAPHIE UND CORTICOGRAPHIE BEI CEREBRALEN KRAMPFLEIDEN. ACTA NEUROCHIRURGICA SUPPLEMENTUM III. (Vienna: Springer, 1955.)

This III. Supplementum of Acta Neurochirurgica contains the papers (partly in the original and partly in abstract form) delivered at two conventions which took place in September 1954 in Bad Ischl, Austria. The Seventh Annual Convention of the German Neuro-surgical Society had as its main topics cranioplasty, radiography of the skull and arteriography particularly with regard to brain tumour diagnosis. These problems are discussed extensively by leading European workers in the respective fields. In addition, several papers dealt with related problems of a more general neuropsychiatric interest. M. Milletti (Bologna, Italy) discusses the thrombosis of the carotid artery, a topic which is finding increasing interest in many neurological centers. On the basis of 450 cases described in the literature and 21 of his own he stresses the relative frequency of this condition and states that the diagnosis can be made on clinical grounds (before arteriography) by palpation of the internal

carotis in the pharynx and by measuring the systolic retinal pressure which is found lower on the side of the thrombosed vessel. Of general interest is also the paper by Nylin and Blömer who measured cerebral blood flow by means of radio active isotopes and state that they are now able to measure not only the blood flow through the brain as a whole but also that of each hemisphere separately.

The main topic of the I. Convention of the Austrian Electroencephalographic Society was electroencephalography and corticography in cerebral convulsive diseases. Prof. Hoff, head of the Department of Neurology and Psychiatry of the University of Vienna delivered an interesting lecture on temporal lobe epilepsy. Its clinical manifestations comprise psychic and somatic reactions and generally represent a tendency towards homeostasis of the cerebral dysrythmias as well as of the psychic disorder. Fishgold (Paris) in his article on electrocorticography gives a concise historical survey of the changing viewpoints of neurosurgeons, from Foerster to Penfield, towards focal epilepsy and their criteria for removal of a lesion. Monnier (Geneva) reports on the results which he, in collaboration with different neurosurgeons, achieved in conditions of intractable trigeminal neuralgia by stereotactic coagulation of the nucleus ventralis posterior of the thalamus. The psychiatric sequelae are similar to those of frontal lobotomies, as the patients are indifferent to their pain, sometimes a little euphoric, frequently hyperemotional. Their personality is less colorful, less lively, particularly after bilateral coagulation. The latter may lead to late vegetative signs, among others to impotence in men, to severe trophic changes in the extremities and to paralytic neurokeratitis.

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Neurology and Psychiatry in Childhood. Research Publications of the Association for Research in Nervous and Mental Disease, Vol. XXXIV, Edited by *Rustin McIntosh, M. D.*, and *Clarence C. Hare, M. D.* (Baltimore: Williams & Wilkins Company, 1954.)

The subject of the *XXXIV*th research publication of the Association for Research in Nervous and Mental Disease is "Neurology and Psychiatry in Childhood." It is highly interesting and informing for the neurologist and the child psychiatrist, because it covers in a large range results for new research, change of points of view and clarifications in both fields. The first part of the book, whose topic is "Infections of the Central Nervous System" gives among others a report by J. E. Salk about the problems for vaccination against poliomyelitis which may answer several questions. The second part brings a great deal of material in regard to the "Developmental and Traumatic Aspects," including a paper by J. Ransohoff and S. Carter, "Hemispherectomy in the Treatment of Convulsive Seizures Associated with Infantile Hemiplegia," where the authors recommend the surgery in a few carefully selected cases. They did not find any remarkable lowering of their 3 patients' I.Q., but did find improvement in their behavior. Abner Wolf and D. Cowen publish in the third part, "Functional and Degenerative Disturbances," 13 cases of chronic degenerative brain disease and demonstrate that in all these cases, divided in 4 groups, anoxia seems to stand out as the pathogenic factor. A thorough list of references makes it possible to follow the research done in this field. "Roentgenographic Aspects" are taken up in the fourth part.

The child psychiatrist will especially enjoy the fifth part, "Psychiatric Aspects." Here, R. Rabinovitch and his staff make an excellent attempt to classify the cases of reading difficulties. The confusion in this field and the lack of differentiation has certainly troubled many child guidance clinics. Rabinovitch suggests in the paper, "A Research Approach to Reading Retardation," a much clearer differentiation between primary and secondary retardation, dependent on the degree of involvement of organic factors.

In several papers in the fifth and sixth part of the publication we find a definite tendency to a multidimensional approach to psychiatric problems, concerning diagnosis, etiology and treatment. A. Blau stresses the necessity of careful investigation in "The Psychiatric Approach to Post-traumatic and Post-encephalitic Syndromes," where he demonstrates with case material how easily the diagnosis of organic damage can be placed with neglect of the environmental and emotional constituents and, therefore, influence the therapeutic approach unfavorably. J. C. Hirschberg and K. N. Bryant give a survey about "Problems in the Differential Diagnosis of Childhood Schizophrenia" in regard to classification, diagnosis, etiology, treatment, and come to the conclusion that "usually there is a complex interaction" of constitutional and psychological factors, no "either or."

It is impossible to do justice to a book with so many interesting and important papers in a brief review. The reviewer had, therefore, to limit herself to a short report of some of them, but it cannot be stressed enough how much stimulation it provides for the readers of both fields.

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Liver, Biliary Tract and Pancreas. By *Frank H. Netter*, M. D. CIBA Collection of Medical Illustrations, commissioned and published by CIBA. (Boston: Little, Brown & Co., 1957. $10.50.)

The third volume in the estimated nine-volume, twenty-year project to create for medicine the first definitive collection of authentic, full-color illustrations of every significant segment of the human body and diseases that affect it, has been published.

The artist of the entire series is the country's leading medical illustrator, Dr. Frank H. Netter of Norwich, Long Island. The undertaking is so vast that Dr. Netter will be devoting virtually the

best of his productive years to completing the series.

Two volumes have already been issued: *Nervous System and Reproduction System.* Part III incorporates a new feature designed to enhance the book's value as a versatile, multi-purpose aid to clinicians, teachers, researchers and students. This feature consists of literature references for the convenience of those wishing to follow up any topics discussed in the text. The 165 pages include 133 full-color plates by Dr. Netter.

Contributors and consultants to Part III were: Drs. Oscar Bodandsky, chief of the department of biochemistry at Memorial Hospital; Eugene Clifton, associate professor clinical surgery, Cornell University Medical College; Donald D. Kozoll, associate attending surgeon, Cook County Hospital; Hans Popper, director, department of pathology, Mt. Sinai Hospital, and Victor M. Sborov, assistant clinical professor of medicine, University of California Medical School.

The books in this series should prove invaluable to the anatomist and pathologist and to the physician and surgeon. They are also valuable as works of reference in medical libraries. All volumes in The CIBA Collection are sold at cost as a service to the medical profession and medical students.

C. B. F.

PERSONALITY IN YOUNG CHILDREN. Vol. I: Methods for the Study of Personality in Young Children. Vol. II: Colin—A Normal Child. By *Lois Barclay Murphy, Ph.D.* (New York: Basic Books, Inc., 1956. $10.00 the set.)

These volumes are the product of Dr. Murphy, and her 11 collaborators, during her 15 years of research on the develpment of normal children at the Sarah Lawrence Nursery School. The author had been impressed as early as 1930, that there was a tremendous hiatus in the data available regarding emotional development of normal children. Such data would be needed to develop a depth psychology which could render meaningful temperamental differences, the dynamic flux of everyday life, and make possible a closer empathy with the individual child. Young children are notoriously difficult to study by the conventional verbal methods used with adults which meant that new techniques had to be developed that would give us clues to the inner emotional life of the child.

Volume I is devoted to a description of the methods that Dr. Murphy and her associates have developed. Part I, "Experiments in Free Methods," describes the various means that give the child the maximum opportunity for free play. The major portion is given to a discussion of miniature life toys, of which varying combinations are ubiquitous in the play rooms of child psychiatrists. Materials, methods, illustrations of behavior by various children, recording and analysis of results are given for this approach and the others throughout the book. The author does not advocate precipitating these methods into a rigid form, but presents her work in detail, to show what can be done and to encourage modifications. A number of photographs illustrate some of the patterns seen with the use of the toys. Sensory toys are selected to see how the child responds to tactile, auditory, visual and olfactory stimuli. Dough and cold cream methods were devised to play a similar but simpler role for the two-to-three-year-old that paints and fingerpaints do for older children. Trude Schmidl-Waehner contributes a chapter on painting and Anna Hartoch does one on the Rorschach examination. Part 2, "Experiments in Group Play and in Readiness for Destruction," is by L. Joseph Stone. Group games are both structured so that a child can spontaneously assume leadership, or is assigned that role for a time. Aggressive and destructive impulses are studied through the use of balloons. Part 3, "Experiments in Active Play Techniques," is by Eugene Lerner. These researches focus on the study of ego development by use of standardized play techniques. Blocking techniques were used to study the child's handling of frustration. Part 4, "Observing Children in Nursery School Situations," is by Evelyn Beyer.

This volume closes with appendices largely presenting methods of analysis of the various techniques, and an adequate index. These studies are based on work previously reported in *Methods for the Study of Personality in Young Children.* Vol. 6 No. 4 of the Monographs published by the Society for Research in Child Development. Dr. Murphy has reworked and extended much of her work, but large parts of the remainder of the book are identical with 1941 reports.

Volume II presents Colin, a normal child, during his 3 years at the Nursery School. Observations are reported in great detail but are edited to avoid repetitiousness and detailed analysis. From the pages emerges a little boy who, through being presented in a variety of circumstances, gives us an opportunity to see how he fluctuates and is consistent, how he attempts to solve problems and frustrations, but especially his vibrant participation in life. The book is divided into three equal sections. The first presents Colin, as seen by his nursery school teacher, while the second illustrates how he responded to the various projective tests described in the first volume. Part 3 summarizes and interprets the previous material. One is impressed by how complex the developing personality can be, but nevertheless, themes can be seen which help facilitate interpretation. Dr. Murphy is right in stating that within these records lie observations that cannot be completely explained by any one school of psychology, psychiatry, or psychoanalysis. This suggests that all the pioneers had valid insights into personality, but it still remains for us to weigh, verify, and fuse these concepts into a meaningful whole.

Volume I will be of value to those who do research and therapy with young children, while Volume II although a research volume, would be of interest to anyone who has to deal professionally with young children. One awaits however, further writings from Dr. Murphy wherein she summarizes and interprets her experiences with the large number of children she has studied.

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THE FIELDS OF GROUP PSYCHOTHERAPY. Edited by *S. R. Slavson.* (New York: International Universities Press, Inc., 1956, pp. 338. $6.00.)

This volume contains 19 essays written by different authors, describing various applications of group therapy. Each contributor has had considerable experience with the field he discusses. Thanks to skilful editing there is a minimum of repetition and a uniformly high level of organization and style. Each application is set in perspective with respect to its history and its current status, is documented by an excellent bibliography, and amply illustrated with case material.

Small groups appear to be particularly congenial to the American culture. As the editor points out in the introduction, group therapy has "met with singular receptivity not only from professionally trained persons and patients, but from the general community as well." (pp *xi*) In its various modifications it has become a means of attempting to ameliorate almost all forms of personal distress and organizational strain. At its periphery group therapy merges with group discussion techniques and becomes integrated with methods of community and institutional organization. Of the 19 chapters, only 8 are concerned with medically defined patients or settings, such as mental hospitals, addicts, alcoholics, and private practice. The rest cover such topics as delinquents, unmarried mothers, community mental health and industry.

It is instructive to compare this book with its counterpart, the *Practice of Group Psychotherapy* which, under the same editor, appeared in 1947. Besides including a much wider range of topics, the current volume reflects the increased amount of information about group therapy gained in the past decade. The chapters contain more references to the literature and better balanced expositions with more summarizing of experiences, and less individual case studies or excerpts from group meetings. But there has been no appreciable advance in conceptualization, although this has become elaborated in certain areas, or change in the nature of the material presented. The latter still consists almost exclusively of clinical reports of experience. As is true of all reports of psychotherapy, these experiences seem practically always to accord with the therapist's original formulations, leading to the uncomfortable suspicion, for which there is a growing body of evidence, that psychotherapy has a built-in device which causes the patient to produce material confirming the therapist's preconceptions. In this case the theoretical formulation is psychoanalytical.

One reason for the failure to make significant gains in conceptualization or factual knowledge lies in the relative lack of good experimental research. As the chapter on research points out, only about 2 percent of the extensive literature in this field could be classed as reports of experiments, and none of these have produced any fundamental insights or discoveries. Recently several ingenious methods of systematically describing and classifying individual interactions and group therapy processes have appeared, which raises the hope that the next decade will witness real progress in the accumulation of experimentally validated information.

In the meanwhile this book offers an admirable survey of some of the major current applications of group therapy. As such it is highly recommended to all those with a general interest in this field. In addition, anyone wishing to embark on any of the group therapeutic approaches covered in this volume cannot de better than to start by reading the appropriate chapter.

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INTERNAL SECRETIONS OF THE PANCREAS. Vol. IX, CIBA Foundation Colloquia On Endocrinology. Edited by *G. E. W. Wolstenholme* and *Cecilia M. O'Connor.* (Boston: Little, Brown & Co., 1956. $7.00.)

This CIBA Foundation volume presents the record of a conference held in London in June, 1955 at which 28 experts from 8 countries discussed the chemistry, biochemistry and physiology of the "Internal Secretions of the Pancreas." In some respects the choice of title would appear to be unfortunate since it seems to beg the question of the plurality of the hormonal factors of the pancreas, an issue which is still not completely resolved as the discussions to some of these papers clearly testify.

Reports of conferences such as this make interesting but difficult reading and the difficulties of this particular volume are enhanced by the order in which the papers appear. A grouping of papers with subsequent discussion of the group (as was indeed done in 2 cases) might have eased the reader's task and, one would imagine, have increased the effectiveness of the conference. The somewhat haphazard ordering of the papers is accompanied by great variation in style, from papers which carefully review a whole field to others which are little more than abstracts of recent laboratory activity.

In the first two papers, workers from the University of Hamburg present cytological and biochemical evidence which they feel favors the hypothesis that there is a secretion of the hyperglycemic polypeptide glucagon, by the cells of the islets of Langerhans, and in a later paper, W. Schulze discusses the efforts of M. Burger to confirm this theory. O. K. Behrens and his associates discuss some of the properties of glucagon and E. W. Sutherland presents his very exciting and elegant work on its mode of action at the molecular level. Indeed, as F. G. Young, chairman of the conference, pointed out in his closing remarks, Sutherland's work appears to come close to fulfilling the biochemist's long-cherished hope of providing "an explanation in terms of the influence on enzyme systems of the action of a hormone." But here again the question may be raised as to whether glucagon may be said to fulfill yet the classic criteria for the definition of a hormone. Attempts to show that these criteria are fulfilled are complicated by the fact that, in some cases the hyperglycemic factors appearing in the blood stream are inhibited by

ergotamine, which has no effect on the hyperglycemic action of purified glucagon. And certainly, there does not yet appear to be any pathological condition which can be confidently referred to as "typo- (or hyper-) glucagonism."

On the other hand, of course, the condition of insulin insufficiency has been known for many years. Insulin itself is perhaps the most thoroughly studied protein and F. Sanger gives a description of some of his most recent investigations on the disulphide bonds of insulin which link together the polypeptide chains, of which he had previously determined the complete amino acid sequence. A number of problems remain in this field; E. Fredericq discusses the heterogeneity of insulin preparations and D. F. Waugh and D. S. Hodgkin present thought-provoking papers on the three dimensional structure of insulin. Any final physico-chemical understanding of the mode of action of the protein hormones must of necessity presume a knowledge of their structure and at the present time it seems that the final solution of these structural problems is bound to come from the X-ray crystallographers. It is therefore very gratifying to realize that workers such as Dr. Hodgkin are entering this exceedingly difficult field.

One of the most useful features of the reports of conferences such as this is the opportunity they provide for a direct comparison of the views of the supporters of rival and perhaps, mutally exclusive hypotheses. In the volume under discussion B. Helmreich and C. F. Cori on the one hand and C. R. Park and co-workers on the other hand discuss the evidence which leads the latter to concur with the hypothesis of R. Levine that the increased uptake of glucose by muscle under the influence of insulin is caused specifically by an increase in the rate of a transport process which carries glucose into the cells. It has long been suggested that insulin affects not only the peripheral utilisation of glucose, but, alternatively or in addition, the output of glucose by the liver. The evidence for a direct influence of insulin on hepatic metabolism is most ably reviewed by C. de Duve. Other papers by P. J. Randle, P. P. Foa, M. G. Goldner, J. L. R.- and R. R. Candela, and C. Cavallero discuss the physiological interaction of insulin and glucagon with each other and with other hormones. The discussions following each paper are reported and it is to be regretted that there is no explicit statement of the extent to which these reports have been edited. The style often suggests *verbatim* reporting, but there is some internal evidence that the speakers have had the opportunity of reviewing their own comments. A statement of editorial policy on this matter would help the reader to evaluate the ideas presented in the discussion periods.

In conclusion, the CIBA Foundation has once again placed endocrinologists in its debt by holding this conference and publishing this volume. The record in its present form will be of great value to workers in this field but a closer briefing of the attending scientists as to the nature of the communications required and more attention to the order of procedure would have increased the usefulness of the volume for workers in less closely related areas of biology and medicine.

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The Recovery Room. By *Max Sadove, M. D.* and *James H. Cross, M. D.* (Philadelphia: W. B. Saunders, 1956. $12.00.)

This is a very instructive, interesting and practical book, combining the work of a number of authorities.

It will be of interest to all medical staff, nursing staff, and administrators. It will be particularly helpful to those who might be contemplating the establishment of a post-anaesthetic recovery room or extension of facilities already available to include what the authors refer to as an "Intensive Therapy Unit" to provide for specialized medical and nursing care in a recovery room area for a prolonged period.

The method of organization of such a unit is set out in detail and in a clear, concise fashion. The principles of the planning are included, as well as suggested plans and diagrams with alternate layouts. Policies to be determined are outlined, as well as staff needs and training. Equipment and supplies required or recommended are listed. There are several chapters devoted to the principles of recovery room management and all specialties are discussed at length.

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The Prevention of Cruelty to Children. By *Leslie George Housden.* (Philosophical Library, Inc. 1956, New York. pp. 379 $7.50.)

This book is a well-written study of the masses of English children born in the lower economic group from the 19th Century to the present. "Cruelty" to Dr. Housden takes into account the physical, environmental and emotional care of these children. The lack of first-hand knowledge of the existing conditions is similar to those of the past. Interested persons have worked tirelessly to secure better legislation; usually, some personal knowledge does bring results. However, even improved welfare laws do not give the full answer to the problem, nor do they alleviate all the suffering.

Dr. Housden feels strongly that there is need for respect of the individual and the hope of a happy family life before some parents will have the motivation to guard and guide their children. Education of the potential parents before their first-born is really necessary.

Public opinion forces legislators into action today as it has done in the past. The present emphasis should be on prevention rather than suppression. Again, the answer is in education. Punishment and fines by the courts for neglect of children is expensive and does not alter the cause. Overcrowding of homes, poor sanitary conditions, lack of money for food, clothes and other essentials lead to desperation, crime and low morality.

In the 19th Century stern materialism was the attitude of the parents and only the most fortunate were considered to have happiness as a right, let alone a need. Children were expected to justify their existence either by prestige or contributing to family funds. Stern discipline was part of the training for the well-to-do and harshness and ill-treatment among the poor. Children had to work very early, sometimes from 3 years up, often knowing nothing except cold, hunger, toil and weariness. Fortunately, in the present there are better labor laws and much less malnutrition. There is still little value placed on human lives of children where poverty, filth and disease are present. Children are added burdens and if they cannot help provide are deserted, abandoned or turned out to find their own way while the parent or parents drink to continue in their dull routine. Living conditions are deplorable in rural sections as well as in the cities. The poverty of living is reflected in a dearth of family life or opportunity. Having been reared in such a home, many see no need of an attempt for another way of life. Exploitation of children to gain the ends of the parents or other adults is still present.

Dr. Housden has divided his book into three parts. The first part is a description of the conditions children of the poorer economic class lived in, the squalor and the heritage they gained from their parents. The exploiting of these children for personal gain included murder in large numbers.

Part 2 takes in the present lives of children of these parents with the inherited traditions of their class. Many improvements are noted with the major one being in less starvation but conditions still hoplessly below those which could conceivably produce good citizens with happy homes and children. Living standards are far below the lowest standard of decency, disease is still high and the individual worth of low estimate. Education is beginning to help in individual cases, along with the untiring work of many agencies both public and private. Experiments are helping a few to lift their own standards while being punished for their ignorance and neglectfulness. These experiments are costly and are able to reach only a few. It is a big step in the right direction.

Part 3 outlines a program for the future to avoid these conditions of the present, placing emphasis on prevention and education. Practically, this program would be rather expensive in the beginning but far less so over a generation of children,—probably not as costly as the present program of suppression and punishment maintained by the government.

This book is well documented having over 400 references and appendices which would be extremely interesting to the student of social conditions.

The author's study of the National Society for Prevention of Cruelty to Children from its foundation in 1884 increases the reader's interest by many case studies. Laws and slow changes in legislation, even for social welfare, are often purely dry facts. His sincere belief in the courage of man if given an opportunity is contagious.

Dr. Housden's definition of parentcraft is "the creation around a child of the environment in which it can maintain its inborn expectation of happiness. It is an affair of the spirit. It is seen in the smile which wreathes a childish face in response to affection. Affection is one of its chief ingredients, understanding is the other. It is the latter which must be taught. In good homes it is learned without direct teaching, through the child growing to adolescence in an atmosphere of good parentcraft. It is never forgotten."

The author's crusading zeal is meant to inspire many people to help prepare the way for the younger generation of parents in their happy task of parenthood.

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Louisville, Ky.

Medizinische Psychologie. By *Ernst Kretschmer.* (Stuttgart, Germany: Georg Thieme Verlag, 1956.)

This is the 11th German edition of a famous book—and in the reviewer's opinion, a great book, written by the Dean of German psychiatry, a man who demonstrated his courage, creativeness, critical knowledge and broad scope. The book has been translated into many other languages, including English, but essentially it remains a German book, and will impress some American readers as a rather foreign philosophical and psychological approach to the subject. The first sentence of the book: "Seele nennen wir das unmittelbare Erleben." containing two almost untranslatable nouns—pillars of a subjective approach to psychology—denotes certain aspects of the author's viewpoint. Actually Kretschmer's approach is unique with a strong emphasis on the functional relationship between structure and function of the body and psychological disposition, largely based on his own earlier research. Yet, in spite of such a specific view, this book is one of the best texts in medical psychology.

In this edition the reader will find considerable revision and addition of material in the chapters on psychotherapy. This review of literature is apt and covers not only German but the international literature on the subject. The book is not suited for a basic textbook in American medical schools, but it is a stimulating and comprehensive review and integration for the more advanced student of the field.

F. C. Redlich, M. D.,
Yale University School of Medicine.

IN MEMORIAM

FREDERICK W. PARSONS, M. D., 1875–1957

With the passing of Frederick W. Parsons, psychiatry lost one of its distinguished figures and we of New York sustained a loss that will be difficult to replace. Dr. Parsons was educated in Buffalo, and received his medical education at the University of Buffalo from which he graduated in 1901. Shortly thereafter he joined the state hospital service and was placed on the staff of the Hudson River State Hospital at Poughkeepsie. He served in that capacity until the United States declared war on Germany. He enlisted in the army medical corps in 1917 and spent some time studying neuroses in London. Shortly after the American Army arrived in France the base hospital #117 for war neuroses was established at La Fauche. Dr. Parsons succeeded Col. Bell as commander of this hospital and had under his command a distinguished series of psychiatrists. He served in this capacity until the signing of the Armistice. When he returned to New York he was appointed medical inspector of the state hospital service and then became superintendent of the Buffalo State Hospital, where he did outstanding work in developing outpatient and occupational therapy facilities and in developing all the facilities of the hospital.

In 1927 after some of the original reorganization, Dr. Parsons was named by the Governor, State Commissioner of Mental Hygiene. He retired in 1937, after having effected outstanding advances in the reorganization of some of the faults of the state hospital services.

It was during Parsons' tenure of office that the system was adopted of placing convalescent patients who were about ready to be discharged in thoroughly approved families relatively near the hospital, which was an intermediate step in order to avoid the abrupt change from the close regimentation of the hospital to the complete freedom of civilian life. He was also responsible for the addition of several new hospitals throughout the state, the most notable of which was the Pilgrim State Hospital at Brentwood, Long Island. In his quiet persuasive way he earned the respect, admiration and loyalty of all those who worked under him. He was never too aggressive and always calm, courteous and understanding. Those of us who worked with him were always sure of sound, conservative advice and a wisdom that comes to relatively few. Wherever it was possible he gave enthusiastic support to the ideas of outpatient clinics sponsored and maintained by the staffs of the various state hospitals.

He was a loyal supporter of The American Psychiatric Association and served faithfully on several committees, the most important of which was the budget committee.

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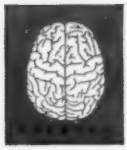

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1. Sainz, A.: Personal communication.
2. Hutchinson, J. T.: Evaluation of Pacatal in Psychotic States, address before the American Psychiatric Association, Nov. 16, 1956.
3. Bowes, H. A.: Am. J. Psychiat. *113*:530 (Dec.) 1956.

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1. Hollister, L. E., Krieger, G. E., Kringel, A., and Roberts, R. H.: Ann. New York Acad. Sc. *61*:92 (April 15) 1955. 2. Hoffman, J. L., and Konchegul, L.: Ann. New York Acad. Sc. *61*:144 (April 15) 1955. 3. Kline, N. S., and Stanley, A. M.: Ann. New York Acad. Sc. *61*:85 (April 15) 1955.

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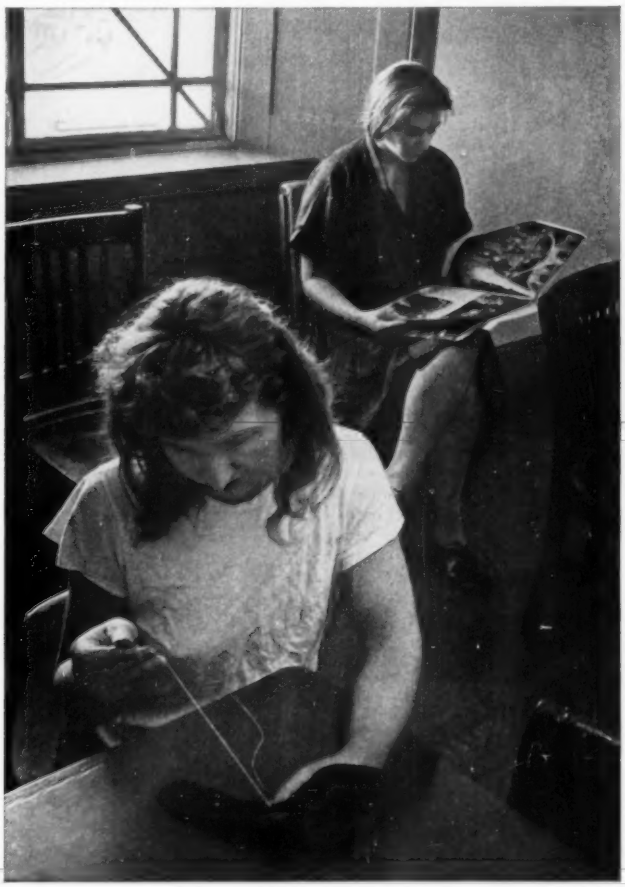

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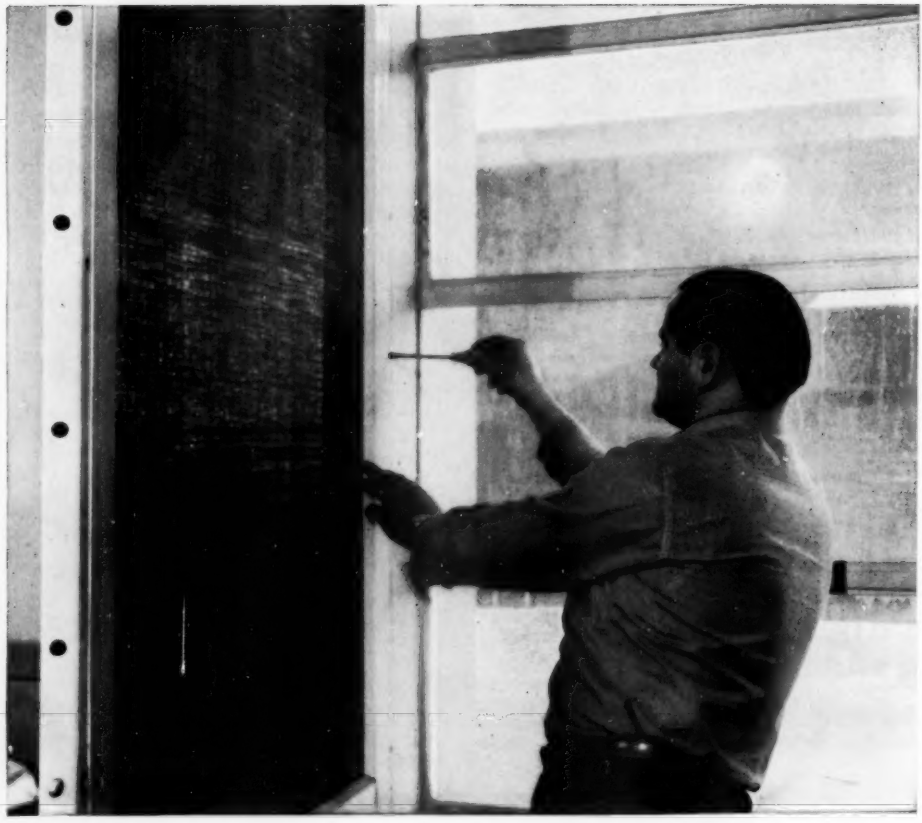

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1. M. Clin. North America 38:485 (March) 1954. 2. J.A.M.A. 162:1031, 1956. 3. J.A.M.A. 156:680, 1954. 4. Yale J. Biol. & Med. 28:308, 1955/56.

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References: 1. Rinaldi, F.; Rudy, L. H., and Himwich, H. E.: Am. J. Psych. 112:343, 1955. 2. Browne, N. L. M.: J. Nerv. & Ment. Dis. 123:130, 1956. 3. Coats, E. A., and Gray, R. W.: Nebraska St. M. J. 41:460, 1956. 4. Cohen, S., and Parlour, R. R.: J.A.M.A. 162:948, 1956. 5. Feldman, P. E.: Am. J. Psych. 113:589, 1957. 6. Bowes, H. A.: Am. J. Psych. 113:530, 1956.

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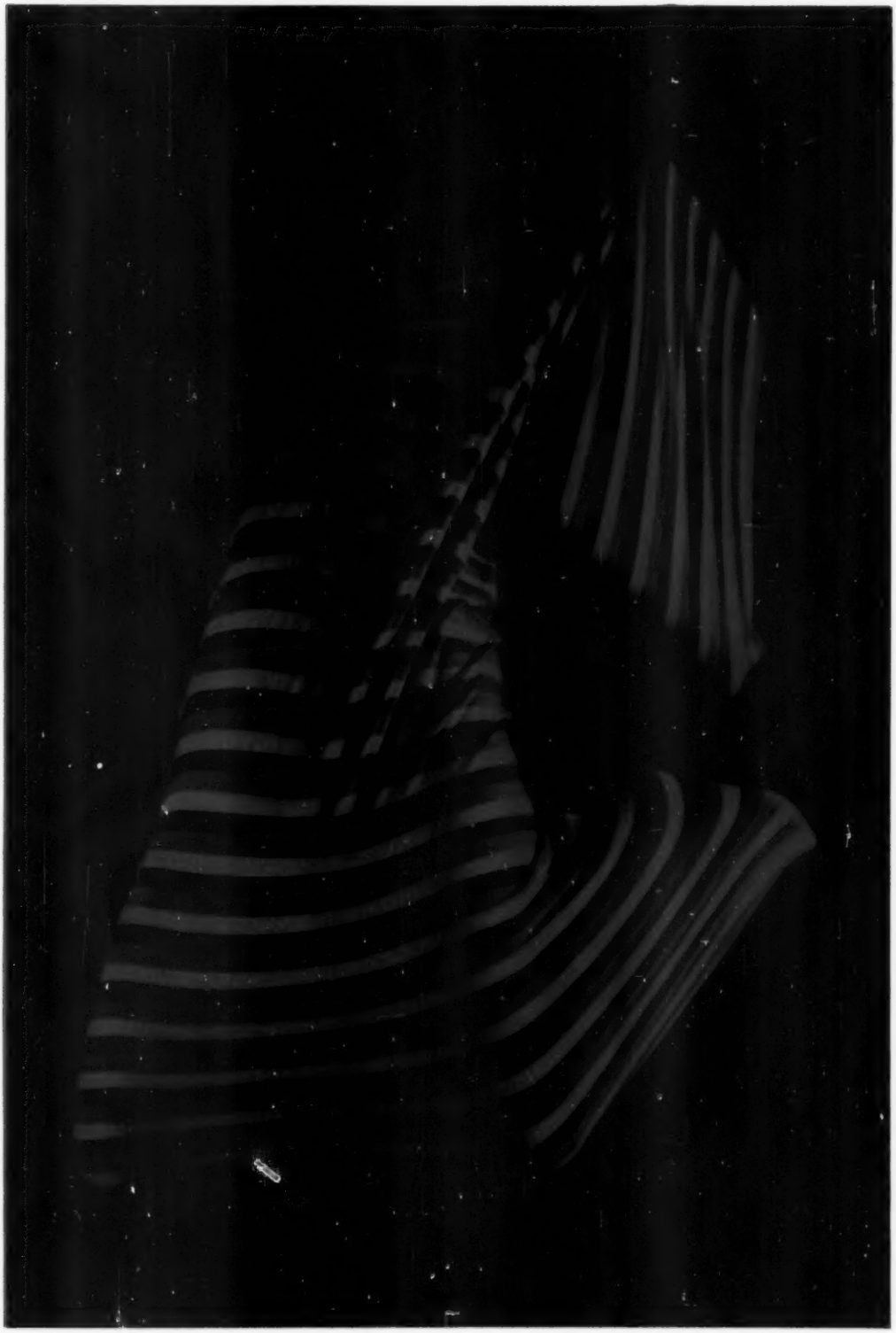

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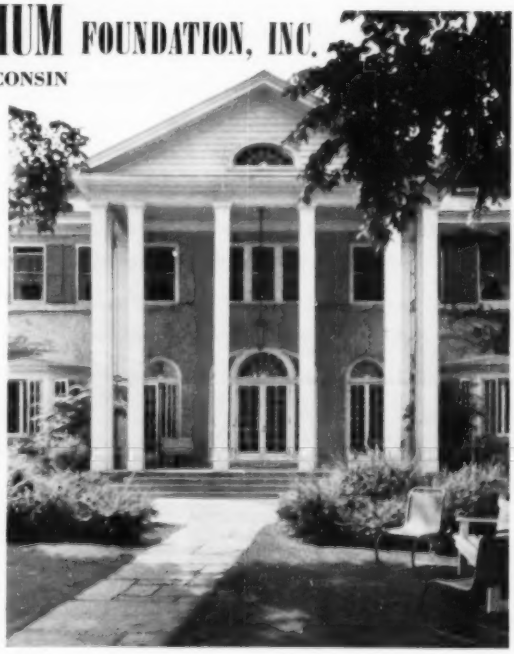

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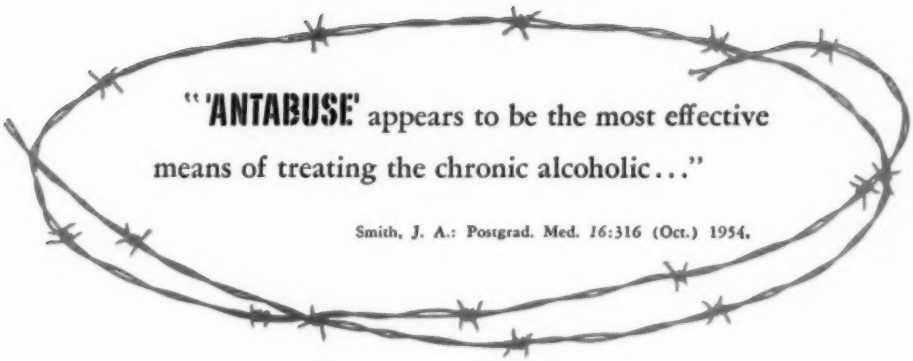

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